

# **Participant's Guide**

**HIV AIDS 500 501**

# **FDOH The Basics of HIV/AIDS Counseling, Testing and Linkage Course**



**HIV/AIDS 500**

**&**

**HIV/AIDS 501**



**HIV Prevention Counseling  
Testing and Linkage Course**

**2018**



**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

**Rick Scott**

Governor

**Celeste Philip, MD, MPH**  
Surgeon General and  
Secretary

**Vision:** To be the Healthiest State in the Nation

Dear Course Participant,

Of the estimated 130,000 people in Florida who are infected with HIV, approximately 80% know their status. Our goal is to reach the remaining 20%. It is critical to Florida's HIV prevention efforts for persons to know their HIV infection status and for infected persons to be linked to care as soon as possible. Effective HIV prevention intervention necessitates all Floridians have an opportunity to learn how to protect themselves from HIV. Encouraging people to know their HIV infection status can help improve their quality of life and break the chain of HIV infection in Florida.

HIV is a behaviorally transmitted disease that is preventable. The HIV 500/501 course you are taking is going to cover many topics associated with the transmission of HIV and some of it may be sensitive in nature. Topics will include drug use/abuse, domestic violence, human sexuality, and sexual practices.

The modules in the manual can serve as a comprehensive reference guide for anyone delivering HIV counseling, testing and linkage activities, whether you are from the public or private sector. We appreciate your professionalism while reviewing this document and participating in class exercises.

By agreeing to participate in this training program, you will gain a greater understanding of HIV/AIDS, HIV testing concerns, and personal risks. Through your efforts, and efforts of others like you, we are making a difference in the fight against HIV/AIDS and the issues surrounding this illness throughout the state of Florida.

If have any questions about the class or HIV, please contact your local HIV/AIDS Program Coordinator.

Sincerely,

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*NOTE: If you recognize changes that should be made to update this manual, please contact the HIV Prevention Program at this address, fax or phone number.*

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## **ACKNOWLEDGMENTS:**

The HIV/AIDS Section would like to thank the following individuals for the time and effort they put into the production and editing of this manual:

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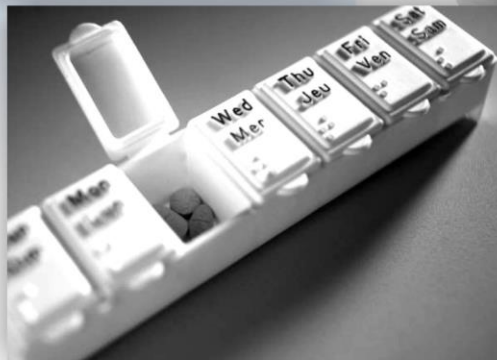
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# **Module I**

## **HIV/AIDS 500**

### **The Basics of HIV/AIDS Counseling, Testing and Linkage**





# **MODULE I**

## **HIV/AIDS 500**

### **The Basics of HIV/AIDS Counseling, Testing and Linkage**

# **Human Immunodeficiency Virus (HIV)**

## **Acquired Immune Deficiency Syndrome (AIDS)**

### **500 COURSE OVERVIEW**

This course is the prerequisite for entry into the HIV Prevention Counseling, Testing, and Linkage course (HIV/AIDS 501). Participants cannot substitute any other course, including the HIV/AIDS 101 course. This course is intended for persons who will be providing HIV prevention counseling, testing, and linkage.

Completion of the 500 course will enable participants to:

- ☐ Demonstrate knowledge of the basics of HIV and AIDS and its impact on families, communities and society
- ☐ Identify several opportunistic diseases and conditions as they relate to AIDS
- ☐ Identify several treatments and medicines related to HIV/AIDS
- ☐ Provide recent statistics regarding the AIDS epidemic
- ☐ Discuss current legal and ethical issues
- ☐ Discuss the modes of HIV transmission and methods of prevention
- ☐ Identify basic concepts of HIV prevention counseling, testing, and linkage (CTL)
- ☐ Demonstrate knowledge of the basics of infectious diseases
- ☐ Measure their comfort level in HIV counseling
- ☐ Complete the written 501 pretest with a score of 80 percent or better.

Participants must also meet all of the HIV counselor's requirements for the Department of Health's Internal Operating Procedure 360-07-17: Minimum Standards for HIV Counselors, Trainers, and Early Intervention Consultants (see Section E: Resources). Counselors are also required to attend annual HIV/AIDS 501 updates. In addition, persons who provide and/or supervise/coordinate HIV prevention counseling, testing, and linkage programs should follow procedures and guidelines in the Department's Internal Operating Procedure 360-09-17: Provision of HIV Testing and Linkage Services (see Section E: Resources).

Information in this manual is referenced from credible sources including websites of the Florida Department of Health, the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH). HIV testing counselors, Sexually Transmitted Disease (STD) Disease Intervention Specialists (DIS), and others who use this manual should be pro-active with information research to remain current with HIV and related information.

January 2018

# **CHAPTER 1**

## **The Basics of HIV/AIDS**

# THE BASICS OF HIV/AIDS

## A Brief History of HIV/AIDS

During the turn of the 21<sup>st</sup> century, there was a great deal of media regarding HIV and AIDS. Even after decades of HIV prevention efforts the impact AIDS has on individuals and communities still continues to grow. Over the course of decades, AIDS has become an integral part of the American experience and lexicon. In fact, many users of this manual have known of HIV and AIDS for most or all of their lives. To understand where we are going with this disease, we need to have an understanding of where we have been. A complete “time line” of HIV/AIDS events is available at the following website: <http://www.kff.org/hivaids/timeline/hivtimeline.cfm>.

In 1981, the CDC identified the first cases of a new complex of diseases and conditions in otherwise healthy men who reported having sex with other men, people who shared intravenous (IV) needles, and people who had received blood products. CDC originally referred to this complex as Gay Related Immune Deficiency, GRID, but quickly changed it to Acquired Immune Deficiency Syndrome, AIDS, as it became clear that gay and bisexual men were not the only ones affected.

Working independently, The National Institutes of Health in the US and the Pasteur Institute in France identified the causative agent as Human T-cell Lymphotropic Virus III, or HTLV-III, in 1984. European researchers referred to the virus as Lymphadenopathy Associated Virus or LAV until 1986, when the scientific community agreed on Human Immunodeficiency Virus or HIV as cause of AIDS.

In March of 1985, a blood test that can detect HIV antibodies became available. The sole purpose of this test was to screen the nation’s blood supply to reduce HIV infections through blood products. In 2000, the American Association of blood banks adopted a highly sensitive nucleic acid amplification test (NAAT or NAT) test to screen all donated blood. NAAT and the use of appropriate risk assessments have greatly reduced the risk of HIV transmission from donated blood and blood products.

In 2010, the first National HIV/AIDS Strategy (NHAS) for the United States was released by the Office of National AIDS Policy. This strategy is designed to be a roadmap for states, territories, and communities to use to reduce HIV incidence, increase access to care and optimize health outcomes, and reduce HIV-related disparities.

In 2012, the state of Florida added a “4<sup>th</sup> generation” antibody/antigen screening test to the HIV tests performed on blood and plasma samples sent to the Florida Bureau of Laboratories. The confirmation tests for these samples were changed to a supplemental test and, if necessary, NAAT.

The CDC estimated a total of approximately 1.2 million people in the U.S. were living with a diagnosis of HIV infection through 2015, the most recent year for which this information is available. The Florida Department of Health estimates a total of 114,772 persons with a diagnosis of HIV infection were living in Florida through 2016.

## **The Origin and Migration of HIV**

Several scientific theories have been developed about the origin of HIV. Current theory, developed from international research, is that prevailing strains of HIV arose from a similar yet very different virus called Simian Immunodeficiency Virus (SIV). SIV is found in a subspecies of chimpanzee native to west equatorial Africa. Animals infected with SIV exposed humans through hunting activities. Research suggests that SIV may have moved from one primate species, to humans. Research suggests the virus mutated to become specific to the human immune system and other human receptor cells.

Millions of people in Central Africa became infected with what we now call HIV at the same time HIV was migrating into populations in sub-Sahara Africa, Europe, Asia, and the Americas. Increased commerce and international travel may explain the seemingly sudden rise of HIV across the globe. The worldwide spread of HIV can be attributed to changes in commerce, the “sexual revolution” of the 1970’s, and the quick availability of antibiotics, which treated and cured some STDs.

There are two distinctly different members of the HIV family - HIV-1 and HIV-2. HIV-1 has several groups (M-P) and many subtypes (A-K) each one found in various parts of the world. HIV-2 is more common in West Central Africa, although cases in Europe and the United States have been documented. These two viruses behave in a similar way; however, HIV-2 causes immune dysfunction more slowly. Testing for both HIV-1 and HIV-2 is part of the Florida HIV testing program for both lab-based and non-lab based or point of care rapid testing.

HIV probably spread quickly in certain gay male communities due to the ease of transmission through unprotected anal sex and high number of partners. HIV spread between injection drug users because of the ease of transmission through blood-to-blood contact from sharing needles, syringes, and other drug paraphernalia through trading sexual contact for drugs.

An important fact about HIV is that it mutates-genetically alters from one HIV generation to another. It quickly adapts to its environment, can become less or more

dangerous (virulent), and can make drug treatments a challenge. Mutations have NOT altered HIV modes of transmission.

No matter where it originated or how it became an infection unique to humans, HIV has managed to become a global pandemic effecting virtually every country, social strata, race, ethnicity, and sexual orientation.

## **How HIV Invades the Immune System**

The human immune system is composed of several lines of defense against outside invaders and pathogens. These invaders include bacteria, viruses, fungi, and other parasites. Our defenses against pathogens include the skin, the mucous linings and cilia of the nose and respiratory system. Our blood stream contains a complex group of cells that make up the immune system. These cells are our best defense against infections.

When a pathogen or invading cell called an antigen, like HIV, gains entry into the bloodstream, the immune system reacts by producing antibodies specific for the destruction of that antigen. Antibodies are part of a mobile army of white blood cells- always patrolling and always battling antigens that make their way into the bloodstream. It is important to know that HIV testing technologies are designed to find HIV-specific antigens and/or antibodies.

T4 lymphocytes, also known as T4 or CD4 cells, are the part of the immune system responsible for directing the actions of other immune system cells that attack invading antigens such as HIV. The killer lymphocytes, B-lymphocytes, and T8 cells are under the command of the T4 cells. Without the T4 cells, the immune system fails to function properly, leaving the body defenseless. The T4 cells, along with other cells in the body, have an outer protein called CD4. HIV seeks out CD4 cells when it enters the bloodstream making all CD4 cells found in the immune system, the brain, heart and other organs, targets for infection.

The immune system does exactly what it is supposed to do when HIV enters into the bloodstream-it reacts and produces antibodies specific to HIV, which mark the virus for destruction by other immune cells. However, not all are destroyed. Once HIV enters a T4 cell, it is safe from the immune response and begins the process of reproduction. Once this process starts, HIV is capable of creating billions of new cells every 24 hours.

HIV has a clear plan to enter cells that normally would direct its destruction. Additionally, HIV targets other cells with CD4 receptors including macrophages which ingest bacteria and dead tissue, the spleen, the cells surrounding the heart, and specific brain cells, however, its chief targets are the generals of the immune system –the T-4 cells.

Various test technologies can detect HIV by finding HIV antibodies. Once a person tests positive for these antibodies, he or she will have a diagnosis of HIV infection, which, left untreated, leads to a severe and chronic breakdown of the immune system.

Over time, reduction of T4 cells within the immune system leads to a diagnosis of AIDS. It is important to test and treat early in this infection process. Knowing that you are HIV positive, and seeking medical care and support services are factors that help fight HIV and extend quality of life.

## **Summary**

- ☐ The virus that causes AIDS was identified in the 1980's as HIV.
- ☐ HIV is a human specific virus.
- ☐ There are two types of HIV: HIV-1 and HIV-2.

- ☐ Many HIV tests are looking for both HIV-1 and HIV-2.
- ☐ HIV infects cells fundamental to the proper function of the immune system.
- ☐ People who test positive for HIV have HIV infection.
- ☐ HIV damages the immune system, a condition that leads to AIDS.
- ☐ HIV testing and access to medical care help extend and enhance the lives of the people with HIV infection.

### **The Invader**

HIV is a retrovirus – a microorganism that uses its genetic material, RNA, and an enzyme called reverse transcriptase to make new HIV cells. Once it has invaded the host cell, HIV will turn that cell into an HIV factory. Over time, HIV destroys significant numbers of host cells within the immune system causing immune functions to be deficient.

The moment HIV enters the human body and infects specific T4 cells destruction

starts. This process continues for many months or years until the immune system can no longer fight off infections, which take the opportunity to flourish. This is why AIDS infections are called opportunistic infections or OI.

The presence of HIV, a measurable T4 depletion, and/or one or more opportunistic infections are conditions that define AIDS.

Often you will hear about the “window period”. This term refers to seroconversion-the time between infection and antibody production high enough to trigger an HIV antibody test. Acute HIV infection (AHI) can last days to months after infection. During AHI, a person will be highly infectious and may not test positive or reactive for HIV antibodies even though they have HIV infection.

Some test strategies can detect AHI. During this time acute symptoms may be seen such as fever, enlarged lymph nodes, night sweats or fatigue. Often people in AHI will ignore these symptoms or pass them off as flu.

Because the immune system has not fully responded to HIV, people with AHI churn out large quantities of HIV making them highly infectious. In 2008, statistical research concluded that nearly 50% of all new HIV infections originate from people with AHI.

Infection begins when HIV enters a person’s blood stream. It seeks cells with compatible surface proteins or receptors (CD4, CCR5, CXCR4, and CCR2) to latch onto. Think of a hand fitting into a glove, that is how HIV outer proteins, gp120 and gp160 bind to human protein receptors.

HIV pierces the outer layers of the CD4 cells and injects its genetic material (RNA) into the host cell. HIV manipulates the host cell to use HIV reverse transcriptase to insert HIV RNA into human DNA codes and transform human cellular replication into HIV replication.

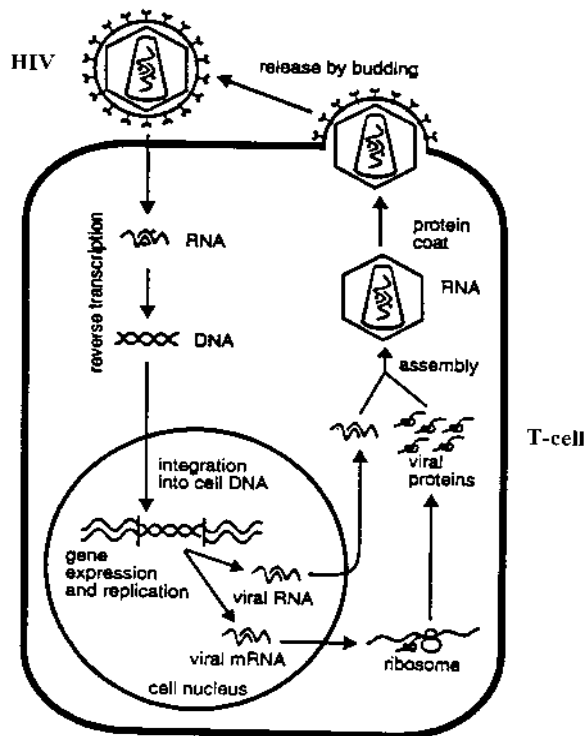
Over time, T-cells are methodically destroyed.

The T4 cells of the immune system have CD4 receptors on their outer coatings. HIV easily latches into these receptors, fitting like a hand into the glove and undetected by the T4 cell.

A normal T4 cell count in a healthy human adult is about 800-1000 T-cells per cubic millimeter ( $\text{mm}^3$ ) (or microliter) of blood. By the time an individual begins to experience AIDS related opportunistic diseases, their T-cell count is usually below 200/ $\text{mm}^3$ . A person living with HIV infection can be diagnosed with AIDS based on a T-cell count under 200/ $\text{mm}^3$  without the presence of an AIDS defining illness. The loss of normal quantities

of T4 cells will lower the body's ability to protect itself from damaging infections and conditions.

Most bodily fluids contain T-cells. Consequently, HIV may exist in almost every human body fluid. Sweat is the only one from which HIV has not been isolated. Since the number of T-cells is minute in fluids like saliva, urine and tears, these fluids do not transmit HIV. There are high volumes of T-cells in blood, pre-ejaculate, semen, vaginal secretions, and breast milk. These body fluids may transmit the virus through both unprotected sexual and blood-to-blood contact, and through breast feeding.



### **"Natural History" or Progression of HIV Infection**

To understand how the treatments for HIV work, you need to understand how HIV invades our cells and tricks our cells into making more HIV. After infection, within the first 24 hours, our immune system releases billions of HIV cells into the bloodstream.

Here is how infection happens: The outer coating of HIV attaches to the surface of the host cell. Once attached or fused into a host cell, an HIV enzyme called integrase drills a hole through the surface of the host and injects HIV genetic material called RNA into the host cell. When the host cell starts to replicate itself, the HIV enzyme Reverse Transcriptase causes HIV to duplicate its genetic code instead of the immune cell code.

The HIV enzyme, Protease, assembles HIV RNA into new HIV cells. The host cell releases new HIV cells by a process called budding. Until the host cell dies, each time it attempts to replicate itself, it reproduces and releases a large number of HIV.

- ☐ **HIV is capable of infecting ALL cells that have CD4 receptors or markers.**
- ☐ **One of the most important CD4 members is the T4 cell of the immune system.**
- ☐ **HIV enters the bloodstream, invades specific cells to use as hosts, and tricks the hosts into producing more HIV.**
- ☐ **HIV uses several enzymes, Integrase, Reverse Transcriptase, and Protease to infect, force HIV replication, and release new HIV cells..**
- ☐ **HIV reprograms the T4 cell to make new virus cells until the host cell bursts.**
- ☐ **Viral replication induces the immune system to produce antibodies to HIV.**
- ☐ **The period between infection and production of antibodies is the window period or time of seroconversion**
- ☐ **During seroconversion, an infected person will have Acute HIV Infection (AHI) and will be highly infectious but may not test positive on an HIV antibody test or show outward symptoms.**
- ☐ **After antibody response, the immune system will keep viral replication in check.**
- ☐ **An infected person may remain symptom free for weeks to years.**
- ☐ **After a time that will vary from person to person, HIV replication resumes and intensifies.**
- ☐ **Continued viral replication leads to depletion of the immune system.**
- ☐ **As immune depression goes on, the infected person becomes susceptible to opportunistic infections.**
- ☐ **AIDS is a condition caused by HIV.**

- **The proper use of anti-HIV medications can make HIV infection a chronic and manageable condition and reduce HIV transmission.**

### **Opportunistic Infections and Conditions**

When the T-cell count of an infected person falls to approximately 200 per cubic millimeter (mm<sup>3</sup>), opportunistic infections (OI) will usually occur. OIs happen because the immune system is compromised or deficient. A person with a healthy immune system and a normal T-cell count would probably not experience an opportunistic disease even though the pathogens of these conditions exist in many healthy individuals. A healthy immune response contains these infections. Many AIDS-related OIs are from pathogens that we live with every day. Someone with HIV who has a depleted immune system may experience one of these natural pathogens as an AIDS-related opportunistic infection.

Over 25 opportunistic infections and conditions are associated with AIDS. Proper treatment may prevent many of these infections; however, infections happen at any time.

Several types of causative agents are responsible for these opportunistic diseases and conditions. These agents are viruses, bacteria, fungi, protozoa, and cancers.

The following is a list of diagnosed AIDS OI and conditions:

Candidiasis - A fungal infection commonly known as “thrush”. This is naturally occurring fungus which lives in human gut. Candidiasis appears as white, sometimes painful patches on the tongue and other oral mucous membranes, in the trachea, the esophagus or the lungs. Several medications are available for treatment.

Invasive Cervical Carcinoma – A potentially fatal cancer of the cervix.

Coccidioidomycosis - This fungal infection is found most often in HIV-infected individuals who live in the southwestern United States. In people with healthy immune systems, this is a self-limiting infection. Usually starting in the lungs, this condition can spread to other parts of the body. Several anti-fungal treatments are available.

Cryptococcosis - This fungal infection usually involves the lungs. However, it may spread to other parts of the body, including the central nervous system. Anti-fungal medications are available, but lifetime treatment is necessary.

Cryptosporidiosis - This is a protozoal infection of the inner lining of the intestines. For someone who is immune compromised, the diarrhea it causes can be life

threatening. Hydration therapy is the only available treatment, although experimental medications may be obtainable.

Cytomegalovirus (CMV) - This viral infection ranges from benign to severe depending on age and immune status. It can cause brain damage, colitis, pneumonia, and blindness. Several antiviral medications are available to treat CMV retinitis.

HIV Encephalopathy - This may be any disease of the brain directly related to HIV infection. This condition is also referred to as AIDS Dementia Complex and affects the central nervous system. Available medications can reduce or reverse symptoms that include poor concentration, forgetfulness, slowness, balance, and behavioral problems.

Chronic Herpes Simplex – A virus transmitted through sexual or other intimate contact. Symptoms last longer and can recur more often in an individual with a compromised immune system. Medications are available for control of herpes, but no cure currently exists.

Hepatitis- Viral hepatitis causes a chronic infection of the liver.

Histoplasmosis - This is a fungal infection that may be pulmonary (in the lungs) or disseminated. Symptoms are similar to those of tuberculosis. Therapeutic medications are available.

Chronic Intestinal Isosporiasis - This is a protozoal infection that causes diarrhea and inadequate gastrointestinal absorption. Medication is available for this infection.

Kaposi's Sarcoma - This rare cancer was first recognized in elderly men of Mediterranean heritage in the late 1800s, and it may attack people with AIDS when their immune system is compromised. Purplish-gray lesions usually occur on the extremities, although they may be found anywhere on the skin and on internal organs. Treatments include chemotherapy, radiation therapy, surgery, and alpha interferon with antiretroviral therapy.

Non-Hodgkin's Lymphoma - This refers to a group of similar solid type tumors that includes diffuse histiocytic lymphomas and Burkitt's or non-Burkitt's lymphomas. Several types of chemotherapies are available as treatment.

Primary Lymphoma of the Brain - This is a type of cancer found in the central nervous system and was very rare before the beginning of the AIDS epidemic. Although radiation therapy is used as a treatment, prognosis for recovery is poor.

Mycobacterium Avium Complex (MAC) - This is a common bacterial contaminant in the southeastern United States. It is not transmitted person to person, but causes chronic fever, anemia, and wasting (unusual and uncontrolled weight loss) in individuals who have a compromised immune system. Although several experimental medications are under investigation, MAC is treated using combinations of antimycobacterial drugs.

Tuberculosis – A bacteria spread by airborne droplets through coughing or sneezing. It usually infects the lungs but can spread throughout the body. Treatment with multiple drug therapy over a lengthy period is usually required to resolve the infection.

Pneumocystis Pneumonia: formerly known as Pneumocystis Carinii Pneumonia: (PCP) - This protozoal infection of the lungs is the most common of the opportunistic diseases associated with AIDS. Several treatments and therapies are available, including prophylactic medication.

Recurrent Pneumonia - This is any type of pneumonia (inflammation of the lungs) occurs more than once over a short period.

Progressive Multifocal Leukoencephalopathy (PML) - This viral infection affects the central nervous system. There is no approved effective treatment; however, experimental treatments include steroids and other antiviral medications are available.

Salmonellosis - This bacterial infection affects the gastrointestinal system and is caused by ingesting contaminated raw foods. Several medications are available as treatment, but for a person with a compromised immune system, resolution of symptoms is very slow.

Toxoplasmosis - These protozoa can attack the brain and central nervous system. Common in Florida soils, many people live with this parasite for decades without problems. It is usually caused by exposure to cat feces but can also be caused by eating some types of raw meat. This disease is generally only a problem for women who are infected during pregnancy and for individuals with compromised immune systems. Medications are available.

Wasting Syndrome - This is a significant loss of weight (defined by CDC as more than 10 percent of baseline body weight) in the absence of any other underlying intestinal cause, and directly associated with HIV infection. Therapy can include a dietary change to high protein food supplements and treatment with appetite stimulants, anabolic steroids and human growth hormone.

Because of modern anti-HIV medications, the time from when a person becomes infected with HIV until they begin to experience life threatening OIs and conditions may be decades after infection. With proper care and adherence to treatments, HIV and AIDS become chronic and manageable conditions.

It is extremely difficult to predict if someone may die of AIDS. While there is no cure, survival, and cause of death for people with AIDS have dramatically changed. Survival depends on several factors including knowing your HIV status, having access to care and support services, and following prescribed medications. Many people with AIDS die from conditions associated with long-term treatment, cancers, or other chronic diseases and conditions. Liver failure is second only to HIV as a cause of death among adults with AIDS primarily because of the toxicity of HIV medications and the high percentage of people who are co-infected with hepatitis C.

People with HIV who do not experience a decline in T-cell counts are designated as “long- term non-progressors”.

### **Summary**

- ☐ HIV is a retrovirus that turns human cells into HIV factories.
- ☐ There is often a lengthy period between HIV infection and development of AIDS.
- ☐ The definition of AIDS is: testing HIV positive; having a measurable decline of T4 (CD4) immune cells, and/or a diagnosis of an AIDS-related opportunistic infection or condition.
- ☐ During the acute infection time (AHI), a person may or may not have outward symptoms, or may not test positive for HIV antibodies.
- ☐ Blood, semen, pre-ejaculatory fluid, and breast milk are the common bodily fluids that transmit HIV from person to person.
- ☐ Survival of HIV infection may depend on several factors, one of which is adherence to medications.
- ☐ HIV infection and AIDS can be chronic and manageable conditions.

### **HIV Testing**

Worldwide, HIV antibody testing has been available since March 1985. The 1996 Florida Legislature passed a law allowing for name reporting of HIV-infected individuals. CDC;

however; does not require the reporting of HIV-positive individuals by name. Some states require name reporting for the purpose of partner notification and evaluation, whereas other states require the reporting of test results by basic demographics of age, race and sex.

The Florida Department of Health HIV/AIDS Program operates the largest public HIV testing program in the United States. Only the military conducts more HIV tests than the registered sites in Florida. In 2016, over 386,000 tests were documented from Florida, about half of which were lab-based tests and the other half point-of-care rapid screening tests. Florida testing is from samples that are whole blood, plasma, oral cells called OMT, and for National HIV Behavioral Surveillance, dried blood spots.

The Florida Bureau of Laboratories (FBOL) operates the state labs in Jacksonville, Pensacola, Tampa, Miami and Lantana. HIV testing is performed at the state labs located at Jacksonville and Miami. Some county health departments and testing agencies have in-house labs that prepare samples to be sent to FBOL. Some agencies use private labs for testing.

No person may be tested for HIV without first giving informed consent. "Informed" means that the HIV test has been explained to the client. "Consent" means the client has given permission to obtain a test specimen and, in return, the state of Florida will use all available HIV test technology on that specimen. Risk assessments and/or Department of Health required demographics are completed prior to or after specimen collection.

In Florida, any agency which holds out to the public as an HIV testing location, must, by law, register with the Department of Health and renew their registrations annually. Counselors from these agencies must receive HIV/AIDS 500/501 training and annual 501 updates. Registration and renewals include a list of current site counselor names.

Sites that offer rapid testing must possess a current CLIA waiver from the US Centers for Medicare and Medicaid Services (CMS) and renew as required.

HIV tests can be antibody (looking for immune system response for HIV), antigen (looking for some part of HIV), molecular (looking for HIV RNA or replication activity), or a combination of antibody and antigen. All reactive HIV screening tests, no matter what kind of test is performed, must be confirmed by an FDA-approved confirmation test.

Beginning April 2012, Florida began using an HIV antibody/antigen combination screening test for blood and plasma samples sent to the FBOL. If positive, the screening test is run a second time, and then sent to a supplemental test for confirmation. If the confirmation is positive, the sample is reported back to the test site as positive for HIV antibodies. If the confirmation is negative, the sample is sent to NAAT antigen testing. If NAAT is

positive, the sample is reported back to the test site as positive for HIV antigen; a test result indicating very early or acute HIV infection.

OraSure oral samples sent to the FBOL are screened for HIV antibodies with an Enzyme- Linked Immunoassay (EIA). If the screen is positive, the sample is sent to Western Blot for confirmation. If the Western Blot is positive, the sample is reported to the test site as positive for HIV antibodies. Western Blot can also result in an indeterminate result and the sample is reported to the test site as being inconclusive for HIV antibodies.

Florida has had AIDS reporting since 1981 and HIV diagnostic test reporting on confirmed Western Blot, IFA, and PCR antigen tests since 1997. In 2006, the HIV reporting law was expanded to include all HIV positive or detectable tests as well as the reporting of all babies born to HIV-positive mothers. These reports are made to the health care provider's local health department within 24 hours of birth. Undetectable HIV viral load tests and/or negative PCR or antibody tests became reportable for babies less than 18 months in 2008.

### **Pediatric AIDS**

The term "pediatric AIDS" refers to cases of AIDS among individuals who are under thirteen years of age. Generally, infants with AIDS are those under two years of age.

Almost all children with AIDS in the U.S. were born to an infected mother. As with adults, children can live with HIV infection and AIDS for years to decades and can also experience HIV as a chronic and manageable infection. With adherence to proper medications, many children born HIV infected can live in good health into their teens, and beyond.

### **Treatment**

The FDA has approved a variety of antiretroviral drugs that interfere with the virus's ability to enter or replicate inside a human host cell. To minimize viral resistance, the FDA recommends combination therapy with medications from the same or different classes.

The United States Department of Health and Human Services HIV Antiretroviral Therapy treatment guideline is available online at <http://www.fda.gov>

More than 30 HIV medications and drug combinations have been approved for use by the FDA. Each drug and combination has specific dosing requirements, possible side effects and other quirks. Anyone taking these drugs needs to learn as much as possible about them. These combinations are powerful medications and give people with HIV infection an excellent chance to shut down HIV's ability to replicate and be transmitted to other people.

The goal of HIV treatment is to suppress replication of HIV in order to limit damage to the body's immune system. Successful therapy results in increased CD4+ cell counts accompanied by decreased viral loads. Individuals may respond differently to the same drug combinations, and some may experience side effects that make it difficult to take the drugs as prescribed. Antiretroviral drugs are not a cure for HIV/AIDS, but they can prolong and improve the quality of life for an HIV-infected person.

Antiretroviral Medication classes include but are not limited to the following:

1. Nucleoside Analogue Reverse Transcriptase Inhibitors
2. Nucleotide Reverse Transcriptase Inhibitors
3. Non-Nucleoside Reverse Transcriptase Inhibitors
4. Protease Inhibitors
5. Fusion/Entry Inhibitors
6. Integrase Inhibitors

### **Summary of Stages of HIV Reproduction and Antiretroviral Agents**

- ☐ HIV instructs the host cell to make copies of the original virus. Nucleoside Analogues and Nucleotide Reverse Inhibitors act by incorporating themselves into HIV to stop this process.
- ☐ HIV genetic material is stored on single-stranded RNA instead of the double- stranded DNA found in most organisms. To replicate, HIV uses an enzyme known as reverse transcriptase to convert its RNA to DNA. Non-nucleoside reverse transcriptase inhibitors bind onto reverse transcriptase and prevent the conversion of human DNA into HIV RNA
- ☐ Protease and Integrase inhibitors prevent HIV from being successfully assembled and released from the infected CD4 cell.
- ☐ Fusion or Attachment Inhibitors prevent HIV from entering healthy CD4 Cells by blocking scientific proteins on the surface of either HIV or the CD4 cell.

## **Optimal Therapy**

With current treatment options, there are more than 200 possible three-drug combinations. Selection of the best option is a complex process and should be a mutual decision involving the medical provider and the patient. AIDS info is a central resource for the most recent federally approved treatment guidelines for HIV and AIDS, accessible at [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov).

## **Side-Effects and Toxicities**

The occurrence of side effects plays a large role in adherence to drug regimens, which in turn can influence the development of drug resistance. A primary factor deterring people from starting therapy is the potential of side effects.

**Details of treatment side effect are available from several websites including the CDC, National Institute of Health, The Well, The Body, and WebMD.**

People with HIV should be advised to report side effects – even those that seem minor – to their healthcare providers. The likelihood of drug interactions and the possibility of developing drug resistant HIV or life-threatening hypersensitivity or lactic acidosis make it important to seek expert advice.

## **Other Medications**

Medications are also available for the prevention and treatment of opportunistic infections and conditions. Examples include antibiotics, vaccines for hepatitis A, B, bacterial pneumonias, and prevention and treatment for latent and active TB.

## **Adherence/Resistance**

Adherence to medication regimens is critical in HIV infection because the virus has a very high replication and mutation rate. In the presence of sub-therapeutic drug levels, viral mutations may emerge that will lead to treatment resistance. In addition, HIV develops broad cross-resistance, especially to the most powerful treatments. Failure to stick with the proper way and time to take anti-HIV medications can sharply limit choices of alternative combinations. HIV resistance is determined by testing for the genetic sequences of the virus (genotyping) or measuring specific drug activity against the virus (phenotyping). The tests are expensive but can assist in designing a new anti-HIV plan if there is resistance.

## **Medication and Drug Interactions**

TB medications, over-the-counter medications, alternative and herbal therapies, methadone, and other drugs may have negative interaction with anti HIV treatments. For example, methadone levels are significantly reduced in the presence of certain protease inhibitors and vice-versa so that dosages must be adjusted, and cocaine can increase HIV replication twenty-fold.

For information on interactions between antiretroviral and prescription drugs, check the DHHS treatment guidelines at [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov). Regarding methadone interactions, see [www.harmreduction.org](http://www.harmreduction.org). Regarding antiretroviral interactions with alternative treatments and non-prescription drugs see [www.sweetlove.be/br\\_hivdrugs.html](http://www.sweetlove.be/br_hivdrugs.html).

## **Summary of Anti-HIV Medications**

- ☐ As the anti-HIV medications work to stop the virus from replicating, the amount of HIV in the blood (viral load) drops dramatically.
- ☐ Skipping medication dosage can lead to medication resistance.
- ☐ Medications are working if the amount of virus in your blood goes down and remains low.
- ☐ “Undetectable” means the number of HIV copies in the blood is so low that it cannot be measured by blood tests. It does not mean the virus is gone.
- ☐ It is important to follow all instructions regarding HIV medications since these therapies help provide longer and healthier lives.
- ☐ Interactions with street drugs can slow or stop the effectiveness of anti-HIV medications.

## **Epidemiology of AIDS**

Epidemiology is the study of the cause, source, and number of diseases in large populations. To study HIV/AIDS, information on reported cases and patient demographics must be collected. Most states in the US do require the reporting of HIV, however, CDC does not require states to report HIV at the federal level.

## **Understanding HIV and AIDS Data**

National AIDS surveillance is conducted through a uniform system; all states and territories report AIDS cases to CDC. Since the 1980's, CDC data has been used to monitor AIDS trends. Data are adjusted to take into account reporting delays and the

redistribution of cases initially reported without risk factors. Trends in new AIDS diagnoses no longer accurately represent trends in new HIV infections; this data may represent persons tested late in their HIV infection, who have limited access to care, or for whom treatment has failed.

HIV surveillance is the monitoring of trends and requires the collection of information on HIV cases that have not progressed to AIDS. Areas that require name-based HIV infection reporting use the same system for collecting HIV data as for collecting AIDS data. States and territories report this data to CDC,

HIV/AIDS is a term used to refer to 3 categories of diagnosis collectively: (1) a diagnosis of HIV infection (not AIDS); (2) a diagnosis of HIV infection and a later diagnosis of AIDS, and; (3) concurrent diagnosis of HIV infection and AIDS.

HIV/AIDS information can be found at the CDC and AIDS.gov websites.

The Florida HIV Counseling and Testing Team within the HIV/AIDS Section tracks the positivity rates from all registered HIV test sites and calculates rates of infection by taking the total number of positives divided by the number of tests conducted.

Incidence is the number of new cases per population. Incidence rate is the number of new cases per population reported within a given period of time.

Prevalence is the number of cases in a population at a given time. Prevalence rate is the total number of cases in the population divided by the number of individuals in the population. It is used as an estimate of how common a disease is within a population over a certain period.

Prevalence is usually reported as cases per 100,000 population calculated by taking the number of reported cases and multiplying by 100,000 and dividing it by the population.

### **Worldwide**

Nearly every country in the world has reported at least one AIDS case. AIDS is considered pandemic, or affecting a significant number of countries.

HIV infection is not always tracked, but several sero-prevalence studies have been conducted to determine the prevalence. These studies show an unusually high proportion of positives in specific demographic groups.

Large numbers of AIDS cases have been reported from places like Thailand, France, South Africa and Brazil. During the early 1980s, many countries, including the US, started reporting AIDS cases to the World Health Organization (WHO). However, countries with the largest populations, such as Russia, China, and India, did not report AIDS cases to the WHO until the late 1980s. The highest number of AIDS cases has been reported from the United States. For current epidemiologic AIDS facts sheets on different countries, visit the United Nations Program on HIV/AIDS website at [www.unaids.org/hivaidsinfo](http://www.unaids.org/hivaidsinfo).

In most parts of the world, AIDS cases are reported in women at about the same rate they are reported in men. In the US and several European countries, AIDS cases in men outnumber cases reported in women by about five to one. Worldwide, AIDS is primarily considered a sexually transmitted disease, with a small percentage of cases associated with sharing drug needles. In the US, about one out of every five AIDS cases is associated with injecting drug use and sharing needles.

### **National**

Approximately one-third of all the AIDS cases in the world, reported to the WHO, come from the US. This does not necessarily mean that one-third of all AIDS cases in the world have occurred in the US. The reporting system in the US is more technologically advanced than many other countries, particularly developing countries, where most of the actual cases that occur may not be reported.

In the US, public health agencies conduct HIV/AIDS surveillance activities. These activities include, but are not limited to, visiting doctor's offices, hospitals and other health care facilities. In a developing country, such as Kenya, many people have died from AIDS-related illnesses in rural areas without ever seeing a city doctor. A case such as this would probably go unreported.

More than half of all cumulative reported AIDS cases nationally occur in racial/ethnic minorities. According to published studies, poverty and other social and economic factors probably contribute to much of this discrepancy. Regarding cumulative pediatric cases, nine out of every ten reported cases in children are black or Hispanic. View [www.aids.gov](http://www.aids.gov) for current HIV/AIDS statistics.

To track the extent of HIV infections and to help measure the effectiveness of prevention programs, the National HIV/AIDS Strategy, released in 2010 and updated in 2015, encourages US state health offices and partnered stakeholders to track "community viral loads". Some

states, including Florida, have initiated a means of determining community viral loads by the use of GIS mapping and surveillance data.

## **Florida**

In 2016, Florida had an HIV case rate of 24.0 per 100,000 people which places the state at the third highest among states with the top 10 highest rates. Florida's case rate was higher than the US average case rate of 12.3 per 100,000 people. Miami, FL and Ft. Lauderdale, FL take the top two rankings for metropolitan statistical areas with case rates of 47.0 and 40.1 respectively.

The results show there has been a decline in perinatally acquired HIV births in Florida from 109 cases in 1993, to 8 cases in 2016 (93%). There are various initiatives and resources in place that have allowed for this decrease by further educating local providers in the importance of testing pregnant women for HIV and then offering effective treatment during the pregnancy and at delivery to further decrease the chances of transmission. The initiation of Highly active antiretroviral therapy (HAART) between 1992-1994 played a significant role in the annual drop of perinatal births. Treatment with HAART achieves viral suppression—a very low level of HIV virus in the body—so the spread of HIV is reduced from mother to baby. In numbers of reported pediatric cases of AIDS (under 13 years of age). HIV/AIDS remains a leading cause of death for Floridians 25-44 years of age.

Miami-Dade County reports about 25 percent of all AIDS cases in Florida, yet has about fourteen percent of the state population. The four most southeastern counties (Miami- Dade, Broward, Palm Beach and Monroe) report approximately 50 percent of Florida's AIDS cases.

NOTE: The Department of Health local Area HIV/AIDS Office or county health department may be contacted for information on the latest statistics. You may also go to the Department website at: [www.floridaaids.org](http://www.floridaaids.org)

## **Legal and Ethical Issues**

The Florida Omnibus AIDS Act became law in 1988. Since that time, the Florida Legislature has amended the Omnibus AIDS Act several times to ensure that the law conforms to advances in scientific knowledge, medical treatments, and public perceptions. This law gives the Florida Department of Health the authority to make specific rules based on the AIDS law. What follows is a brief description of Florida's HIV/AIDS law as it applies to Counseling, Testing, and Linkage to care.

### **I. Education**

- A. Education on HIV infection is required for a wide spectrum of health care providers.
- B. The Florida law establishes the educational requirement. Individual licensing boards establish specific requirements for professions.
- C. Health care providers must spend a specified number of contact hours learning about HIV infection.

### **II. Counseling and Testing**

- A. Individuals or clinics that provide HIV testing to identify HIV infection in individuals must first register with the Department. This requirement does not apply to providers who perform or provide HIV testing services which are incidental to the primary diagnosis or care of a patient
- B. Informed Consent
  - 1. In non-health care settings, persons tested for HIV must be informed about the HIV test and agree to be tested. Informed consent must include information on the fact that, if a person tests positive for HIV antibodies, the test result will be reported to the Department and that confidentiality laws apply to protect the client's privacy. The client should also be informed that anonymous (no name used) testing is also available.
  - 2. In non-health care settings, the test subject must give his/her informed consent and it must be documented in the patient medical record. With anonymous testing, there should be no documentation in the confidential medical record that such testing occurred.

3. Florida law requires those who perform HIV tests in county health departments make private counseling available both before and after the test.
- C. Except in a few limited situations, positive test results must be confirmed with a supplemental test prior to informing the test subject of a positive result.
1. Current law permits preliminary HIV test results to be released to the test subject as follows:
    - a. when decisions about medical care or treatment cannot await the results of a confirmatory test
    - b. when there has been a significant exposure, preliminary results can be released to licensed physicians and to the person(s) subject to the exposure.
    - c. preliminary rapid test results can be released in accordance with the manufacturer's instructions as approved by the FDA.
  2. Positive preliminary HIV test results shall not be characterized to the patient as a diagnosis of HIV infection. Confirmatory testing must be conducted as a follow-up to a positive preliminary test.
- D. For pregnant women, HIV testing as well as testing for other sexually transmitted diseases is to be provided as a standard of care at the initial prenatal care visit and again at 28-32 weeks gestation. Prior to testing, practitioners shall notify the woman which tests will be conducted and of her right to refuse any and all tests. If the woman objects to testing, a written statement of objection specifying which tests were refused, signed by the woman, shall be placed in the woman's medical record and no testing shall occur.
- E. Effective July 1, 2002, the Florida Department of Corrections (DOC) was required by law to perform an HIV test on inmates (if their HIV status is unknown) before they are released from prison. The law allows for certain exceptions, such as inmates who are known to be HIV positive or who have been tested within the previous year. An inmate who is released due to an emergency is also exempt from mandatory testing. The DOC is required to notify the Department of Health and county health department where the HIV-positive inmate plans to reside following release. The DOC is also required to provide special transitional assistance to HIV-positive inmates which includes education on preventing the transmission of HIV to others, the importance of receiving care and treatment, a written discharge plan that includes referrals and

linkages to and contacts with county health department and local community- based organizations, and a 30 day supply of all HIV/AIDS-related medications that the inmate is taking prior to release.

F. Confidentiality

1. Release of results to a third party must be specifically authorized by the test subject or his/her legal representative, or court order, or on a need-to- know basis (ex: foster parents of an HIV-infected child).
2. When performing a confidential HIV test, positive results are reportable to the Department of Health. Anonymous HIV testing (no name used) is offered in each county by the health departments and, in some counties, by community-based organizations.

G. It is illegal to donate blood or human tissue if you know you are infected with HIV.

H. Health care practitioners regulated through the Department of Health, Division of Medical Quality Assurance are permitted (but not required) to disclose the test results of an infected patient to the patient's sex and or/needle-sharing partners(s). The health care practitioner must follow the "Partner Notification Protocol for Practitioners", dated March 1999. (This is available on the Florida Department of Health website).

I. All seropositive persons must be asked if they have, or have had, a spouse at any time within the ten-year period prior to the diagnosis of HIV infection. If so, the person should be informed of the importance of notifying the spouse or former spouse(s) of the potential exposure to HIV. HIV-infected persons must be offered the assistance of public health personnel in notifying a spouse or any sex or needle-sharing partners. The provider will refer and link those individuals choosing the assistance of public health personnel to the Department's local Sexually Transmitted Disease (STD) Control Program staff.

J. Partner Services (PS) are provided through the STD program of the health departments.

K. Minors who seek testing or treatment for a sexually transmitted infection (including HIV) do not need parental consent to be tested. They may give their own informed consent.

III. Non-discrimination

- A. It is illegal to use HIV antibody tests or HIV infection to discriminate in areas of employment, housing, public accommodations or government services.
- B. It is illegal to discriminate against health care providers who treat HIV/AIDS patients.

IV. State laboratories

- A. Specific testing procedures are required.
  - 1. If multiple Immunoassays (IA) are positive, a confirmatory test must be done.
  - 2. FBOL uses MultiSpot, Western blot, or NAAT as an HIV confirmatory test. Whether the lab is public or private, a confirmatory test is required before an HIV-positive test is considered conclusive.

V. Public Health

- A. It is a third-degree felony for an HIV-infected person to have sex without first informing the potential partner(s) of his/her HIV status and getting permission for sexual contact. This penalty is increased to a first-degree felony for multiple offenses. (Simply wearing a condom during sexual contact does not exempt an HIV-infected person from informing their partner of their status or from any provision of this law.)
- B. Convicted prostitutes must submit to an HIV test.
- C. All specimens donated to blood, organ or sperm banks are tested for HIV and discarded if positive. The person collecting the specimen shall notify the donor of the presence of the virus.
- D. Victims (or their legal representative) of crimes involving the transmission of body fluids (such as rape or sexual abuse of a child) may request access to the test results of his/her alleged perpetrator.

VI. Insurance and HMOs

- A. Florida law provides guidelines for medical tests.

- B. Insurance companies or HMOs cannot cancel or not renew policies because of HIV/AIDS.

### **Social and Ethical Issues**

Ethical issues go beyond the discussion of what is legal. Ethics deal with perceptions of a person's moral duty or obligation, even when laws may not necessarily require such action. Some may perceive actions that are technically legal differently from being morally ethical.

HIV counselors should be familiar with the social and ethical issues in their community, as well as similar issues in the national and international media. HIV counselors do themselves and their clients a tremendous service by reading and learning as much as possible about the disease and accessing reliable resources to keep their knowledge current on related issues and topics.

### **Discrimination and Stigma**

Discrimination and stigma continue to be problems surrounding HIV and AIDS despite current laws such as the Americans with Disabilities Act that deals with discrimination. Discrimination occurs in varying degrees and can be subtle (avoiding someone in the workplace because there is a rumor that person has HIV) or blatant (firing a person because of that same rumor or because that person does have HIV).

People with HIV/AIDS, as well as friends, relatives and caregivers of infected people, have endured discrimination. Children not accepted in school because they are infected is an obvious example. Some health care providers have refused to treat someone either because of AIDS or because of perceived infection with HIV. Some people have refused treatment from a health care provider due to fear of contracting HIV; and correctional inmates are often shunned by fellow inmates and correctional officers due to misinformation about HIV.

Fear seems to be the root of discrimination despite a great deal of information available to the public. Because knowledge about HIV transmission and epidemiology is available, continued fear and discrimination of people with HIV is unfounded.

Unethical people exploit others for personal or financial gain. Those who are able to sell unapproved or expensive items to prevent or treat HIV/AIDS do so because the seller plays on the fears regarding HIV. Fraudulent and unapproved drugs and therapies continue to sell because HIV-infected people tend to grasp at anything that looks like it might help relieve pain and suffering. Unapproved devices and products marketed to prevent or cure HIV/AIDS are available to a vulnerable public.

Research continues about HIV/AIDS yet there is still much to be learned and applied. Education remains a powerful tool to stop the endemic and reduce stigma. Individuals can learn about HIV and help teach others the facts. Parents can learn the facts and teach their children. Department of Corrections employees can teach inmates the facts. Elementary, middle school, and high school teachers can pass on correct information to children and teens in a sensitive, non-frightening way. Counselors must become more comfortable using ethical and legal norms and standards to guide and limit their actions in all matters affecting their response to HIV/AIDS counseling and testing.

# ***CHAPTER 2***

## ***Transmission and Prevention***

## **TRANSMISSION AND PREVENTION: TWO-SIDES OF THE SAME COIN**

Certified HIV testing counselors are expected to provide HIV prevention messages to clients. To understand HIV prevention, you must first have a firm understanding of how transmission occurs.

Years of research has taught us much about HIV/AIDS. One thing that has not changed is that you cannot talk about HIV transmission without talking about HIV prevention. These two subjects go hand-in-hand.

### **I. Modes of Transmission**

HIV is transmitted from one person to another by body fluids, which carry enough HIV to cause infection. The primary activities which bring most people in contact with HIV, are unprotected sexual contact and by sharing or reuse of HIV contaminated needles and syringes used to inject illegal or legal drugs. In addition, an infected woman can pass HIV to her unborn baby during pregnancy or to her newborn child during childbirth, or through breast feeding. Before March of 1985, receiving blood transfusions or blood products infected many people. Today, HIV infections through receipt of blood products are exceedingly rare in the United States due to intensive screening and use of sophisticated HIV testing.

Exposure to HIV does not necessarily lead to infection. The ease or difficulty of transmission depends on cofactors. As with any virus, a person must be exposed to a certain viral load before becoming infected. It is possible to have sexual contact with an infected individual, be exposed to the virus several times, and not become infected. It is also possible to have sex, just one time with an infected person and become infected from that single contact. Everyone is different, and each immune system protects in varying degrees.

To put it simply, HIV is transmitted by semen and pre-ejaculatory fluid from men, vaginal secretions from women, blood contaminated needles from anyone, and by breast milk during breast-feeding to infants.

#### **A. Sexual Contact**

Sexual contact accounts for most of the HIV cases in the United States and worldwide. The most efficient means of sexual transmission is rectal or anal sex, which is penis to rectum. If an HIV-infected man ejaculates into the rectum of his male or female partner, infection is likely to occur. If the receptive partner in anal sex is infected, he or she may not pass HIV to his or her male partner as easily as in the preceding situation. Rule to remember: If

an HIV-positive man ejaculates into the rectum, vagina or mouth of his sex partner, he is exposing his partner to HIV.

There are several sexually transmitted diseases where, if a man is infected and he has sex with a male or female partner, transmission can easily occur. This is also true of HIV. Regarding penetrative sex with a penis, it is easier for a man to infect his partner, male or female, than it is for a woman to infect her partner, male or female.

Statistics show that women can infect men through vaginal sex, although not as easily as men infect women.

Oral sex presents a risk of infection due to exposure to vaginal fluids and/or pre-ejaculatory and ejaculatory fluids. Oral transmission of HIV is difficult to document, because often a person who is having oral sex, is also having vaginal and/or anal sex.

Female-to-female sexual contact is not a very effective method of transmission unless there is a sharing of vaginal fluids or blood. Women may not recognize female-to-female sex as a potential risk for HIV transmission and may engage in unrecognized risky behaviors. Although the risk of HIV transmission between women may be small, it makes sense for HIV-negative and HIV-positive women who have sex with women to receive information about safe-sex practices with female partners.

There have been several studies done concerning the transmission of HIV and circumcision. The majority of evidence concludes that uncircumcised men are at a higher risk for HIV. One reason may be that the skin underneath the foreskin is kept moist creating a good environment for bacteria and infections to flourish. According to the World Health Organization, there is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Voluntary medical male circumcision should always be considered as a part of a comprehensive HIV prevention package of services that include other methods of prevention and proper condom use.

## B. The STD Connection

CDC has published results of studies showing that the presence of other sexually transmitted diseases (STDs) makes HIV transmission two to five times more likely during unprotected sex. This applies to both lesion STDs where open sores are present, like syphilis and herpes, and to non-lesion STDs, like

gonorrhea and Chlamydia. The presence of STDs increases a person's vulnerability to HIV infection.

### C. Needle-Sharing

The most efficient means of HIV transmission is blood-to-blood transmission. If sufficient amounts of HIV-infected blood get into the body, infection may occur. The exact amount has not been determined; however, it may take as little as a few drops for infection to occur. History has shown exposure of infected blood to skin that does not have open sores or lesions, does not transmit the virus. HIV does not soak into the skin, it must have means of entry into the blood stream through a cut, open wound, or injected directly into a vein or a muscle.

If a person injects drugs into the vein (intravenously) or into the muscle (intramuscularly) **and** shares needles, they are engaging in a behavior that puts them at great risk for transmitting and receiving HIV. This risk may be relative depending on the person's geographic location and the HIV prevalence in that area. For instance, if a person shares needles every day and lives in Miami or Ft. Lauderdale where the frequency of HIV is high, risk of infection may be greater than sharing needles with people in an area with low HIV frequency.

Any type of needle sharing may transmit HIV. For example, injecting steroids and sharing needles with someone else may lead to transmission. Sharing tattoo needles or needles for ear or body piercing may also be a means of transmission. Intravenous infection could also occur among diabetics who share insulin needles. Sharing needles is the behavior that accounts for the second highest number of reported HIV infections and AIDS cases in the United States.

### D. Other Drug and Alcohol Use

Injecting drugs and sharing needles is certainly a behavior that puts an individual at risk for HIV. Other drug and alcohol use, including the abuse of prescription drugs may also affect judgment and put a person at risk because they may engage in risky behaviors that they normally would not do.

The behavior that accompanies the use of drugs such as cocaine, crystal methamphetamine, ecstasy, or other illegal drugs may put a person at risk. For example, an individual who is addicted to a drug may support the cost of their addiction by having sex in exchange for the drug or for money to buy the drug. In the course of a single day, these addicted individuals may each have several

sexual partners and may not be in a state of mind to think about using barrier protection such as condoms.

Alcohol and other drugs may impair good judgment. Without the ability to think clearly, sexual contact may take place with a stranger and body fluids may be exchanged through unprotected sex. It is possible for HIV transmission to occur after one single contact with an infected person.

#### E. Occupational Exposure

There is a risk of HIV infection for anyone who provides health-related services to a person infected with HIV. Coming into direct contact with infected blood in such a way that the blood gains entry into the person's body, may result in HIV infection. Hospitals, clinics and other healthcare agencies have policies regarding Universal Precautions that include hand washing, the use of protective barriers, the proper use and disposal of needles, and cleaning and disinfecting spills. These precautions are for the benefit of healthcare workers and their patients and clients.

### **Modes of Transmission Summary**

HIV passes from person to person through certain bodily fluids, specifically blood, semen, pre-ejaculatory fluids, vaginal fluids, and breast milk. Research has demonstrated only three routes of HIV transmission:

1. Sexual contact with an infected person
2. Mother to child during pregnancy, childbirth, or breastfeeding
  - The risk increases if the mother becomes infected with HIV while breastfeeding, since viral loads are very high in the initial stage of infection.
3. Blood-blood contact by sharing needles and/or syringes, blood transfusion, tattooing, sharing razor blades, or any other objects that can carry blood from one person to another.

#### II. Prevention

People tend to believe that specific, disturbing events they observe happening to others will never happen to them. For example, someone might drive a car without buckling their seatbelt because they are sure the car accidents they read about in the newspaper will never happen to them. A teenager might smoke cigarettes even with the awareness that smoking can cause lung cancer. Teens often believe they will never have cancer because they think it usually takes several decades of inhaling tobacco to cause harm. Young people often have sex without the thought

using measures to prevent unwanted pregnancies or STD's because they are certain these undesirable consequences will never happen to them.

It is certainly easier to deliver an HIV prevention message than to get individuals to change their behavior. It's human nature to have the illusion of invulnerability, or think that bad things we see happening to others will never happen to us. Yet, preventing the transmission of HIV/AIDS is simple. It all comes down to increasing our knowledge of HIV, knowing our HIV status and the HIV status of our partner(s), always using protective measures when appropriate and avoiding risky behaviors.

### **Changing Sexual Behavior**

#### **A. Abstinence and Monogamy**

Abstinence is the only sure way to prevent infection through sexual contact. If a person is not sexually active (these activities include oral, anal or vaginal contact) there is virtually no chance of contracting HIV or any STD through sexual activity.

Having sex with only one uninfected partner is a way to be sexually active and not risk infection with HIV. The words mutual monogamy mean that both partners in a relationship are only having sex with each other.

#### **B. Condoms**

Condoms provide a barrier of protection for those who choose to have one or more sex partners. When used properly, condoms create a barrier that prevents the virus from spreading from an infected individual to someone else.

Condoms are highly effective at preventing many types of STDs including HIV when used consistently and correctly. Most often, human error causes condoms to fail.

Some of the mistakes people make when using a condom are:

- 1) Putting on a condom after sexual contact occurs.
- 2) Using a condom incorrectly. It may not be unrolled all the way or the user attempts to put it on inside out, realizes the mistake, and then turns it right side out.

- 3) Storing condoms incorrectly. Condoms left in extreme heat or cold for prolonged periods or placed into wallets for long periods of time causes them to degrade.
- 4) Using oil or petroleum-based lubricants with latex condoms. Any oil-based lubrication, including hand lotions or massage oil a person might have on their hands, begins to break down the latex and causes it to rip or tear during sexual activity.

Here are some guidelines for using condoms properly:

- 1) Use condoms from start to finish. It does little in the way of prevention to engage in penetration and withdrawal only to put the condom on just before ejaculation. Body fluids are transferred before ejaculation occurs.
- 2) Use condoms one time only.
- 3) Do NOT use condoms past their expiration date.
- 4) Condoms should not be used if the package is damaged or if the condom itself looks discolored, brittle or unusual.
- 5) Condoms need to be unrolled all the way onto the penis, leaving a small area at the tip for the ejaculatory fluid. Pinch the receptacle end of the condom as it is being rolled down onto the penis to prevent air bubbles from being caught at the tip, allowing room for the ejaculatory fluid, and helping to prevent breakage.
- 6) If uncircumcised, pull back the foreskin before rolling the condom down the penis.
- 7) Condoms need to be removed immediately after ejaculation and while the penis is still erect to prevent contents from spilling.
- 8) Latex condoms are more effective at preventing HIV than lambskin condoms.
- 9) Use only water-based or silicone-based lubricant with latex condoms. Never use an oil or petroleum-based lube with latex. **Oil and petroleum-based lubricants can destroy latex**
- 10) Add a small amount of water-based lubricant to the inside of a condom to increase sensitivity and lessen the chance of breakage.
- 11) Store Condoms at room temperature in a dry place. Extreme heat and cold can break down the latex.
- 12) Keep condoms located so they are readily available when needed.

Condoms may be obtained free of charge at county health departments, community organizations and testing sites.

### C. Polyurethane Condoms

Plastic or polyurethane condoms are stronger and more sensitive than latex condoms. Polyurethane condoms have several advantages over latex condoms, such as: oil, water or silicone-based lubricants may be used; they serve as an alternative for individuals allergic to latex; and polyurethane may be more pleasant for individuals who find latex condoms undesirable due to their lack of sensitivity.

The disadvantages of using polyurethane condoms are their cost is considerably more than latex, and they are not as pliable as latex condoms.

### D. Nonoxynol-9 (N-9) and condoms

Studies have shown that Nonoxynol-9, the substance used in many brands of condoms, lubricants and creams as extra protection against pregnancy and STD's, may strip the inner lining of the rectum during anal sex, making it more prone to abrasions and open wounds. By its nature, anal intercourse, with or without a condom, can pose a risk of infection due to tears and abrasions. The golden rule of sex has changed from "Always use a condom!" to "Always use a condom without Nonoxynol".

### E. Female Condoms

The polyurethane female condom is an option for women to protect themselves against HIV and other STDs, particularly when their male partner is reluctant to wear a condom.

There is a distinct advantage for a woman to be in control of her own health. As a female-initiated method, it is an important tool for women who cannot negotiate male condom use due to personal or cultural restraints. Just like with the male condom, to provide protection effectiveness, the female condom must be used correctly and consistently for every sexual act.

Never use the male condom and the female condom at the same time as friction between the two can result in slipping or tearing of either or both condoms.

Advantages of using the female condom include the convenience of inserting the condom into the vagina up to eight hours before intercourse so it does not interfere with the moment. Because it is made of polyurethane, it does not produce irritation or allergic reactions in people sensitive to latex. Like the polyurethane male condom, the consumer also has the option of using either oil

or water-based lubricants, and there are no special storage requirements because polyurethane is not affected by changes in temperature or dampness

Disadvantages of using the female condom include being more costly compared to the male condom. The use of the female condom may also be cumbersome and more difficult if directions are not properly followed, however, the ease and effectiveness of using the female condom should improve with practice.

The female condom is not a replacement for the male condom as a means of contraception or disease protection, but rather an addition to barrier method options. Expanding a person's choices increases protection and worldwide has resulted in an increased number of protected sexual acts.

#### F. Other Barrier Methods of Prevention

For oral sexual contact, whether mouth-to-penis, mouth-to-vagina or mouth-to-anus, barrier methods of prevention must be used to avoid HIV and STD transmission. Condoms, non-lubricated or flavored, may be used for mouth-to-penis protection. If a flavored condom is used, it is advisable to check for any allergic reaction prior to sexual contact. A condom may be cut into a large square and placed over the vagina for mouth-to-vagina protection or placed over the anus for mouth-to-anus protection. Protective "dams", latex and polyurethane, can be used for mouth/vagina or mouth/anus contact. However dams may be difficult to obtain.

Although some may advocate the use of plastic wrap as barrier protection during oral sex, the CDC maintains that there are no data regarding the effectiveness of plastic food wrap in decreasing HIV transmission or any approved by the FDA as a barrier that would decrease the transmission of HIV.

#### G. PrEP

Pre-exposure Prophylaxis (PrEP) is a once-daily pill, taken orally, in conjunction with prevention strategies to reduce the risk of acquiring HIV infection. Currently, the only medication approved by the FDA for PrEP is tenofovir disoproxil fumarate (TDF) 300 mg co-formulated with emtricitabine (FTC) 200 mg, known as Truvada®. PrEP is recommended as a prevention option for individuals at higher risk of acquiring HIV infection, including adult men who have sex with men (MSM), high-risk adult heterosexually active men and women, adult injection drug users (IDU), and adults whose partners are known to be HIV infected.

A series of clinical trials have demonstrated the effectiveness of PrEP. The guidelines are based on strong evidence from PrEP clinical trials that were conducted in high-risk populations. These studies did not find any significant safety concerns with daily use of PrEP.

### **Changing Sexual Behavior Summary**

The most common mode of HIV transmission is heterosexual sexual intercourse. Steps to reduce the risk of sexually acquired HIV are:

- ☐ Abstain from sex
- ☐ Reduce the number of sexual partners
- ☐ Use a protective barrier consistently during sexual contact
- ☐ Avoid sex with people who have multiple partners or are engaging in other high- risk activity, such as commercial sex or intravenous drug use
- ☐ PrEP

- ☐ Be treated for STD infections
- ☐ Talk with your partner about risk

#### G. Abstinence & Harm Reduction with Injection Drug Use

Prevention measures in the injecting drug use (IDU) community take on a hierarchy of effectiveness. The ideal situation would be to remove the behavior from the drug user, get him or her into a substance abuse treatment program and assist in getting him or her off the drug. This prevention measure is not always possible because there are more drug-addicted individuals than existing treatment programs can serve. In addition, even when treatment programs are available, clients may not be ready to accept treatment.

The second-best measure of prevention in the IDU community is **harm reduction**, a way to make injecting drug use safer. Harm reduction includes not sharing needles and works, cleaning needles and works, and needle and syringe exchange programs, which, are prohibited in many states including Florida. Providing those who choose to continue IDU activities with harm reduction information and options will help them understand how to protect themselves from blood-to-blood HIV transmission.

If an injecting drug user continues sharing needles, he or she should clean their needles and syringes. Ordinary household bleach drawn into the needle and syringe can inactivate HIV. The bleach must be drawn into the syringe, shaken and squirted out. This process must be completed three times. Then, water must be drawn in and shaken to rinse out the bleach. This process should also be completed three times since injecting bleach into the veins can be more deadly than HIV.

The least effective means of IDU prevention is to rinse the needle and syringe in any available liquid such as tap or rain water, soda or any drinkable liquid. However, some measure of prevention is better than no measure of prevention. Some communities in the US have implemented needle exchange programs. An injecting drug user can go to a needle drop-off point and exchange his or her used needle for a new, sterilized one. Studies show this method of prevention reduces the incidence of HIV and does not encourage the use of illegal drugs. Additionally, studies show that these programs are effective at getting drug users into treatment programs. The federal government has banned the use of federal dollars to fund needle exchange programs.

Most states and local governments have laws that prohibit the use, sale, and exchange of drug paraphernalia, including needles and syringes that are not doctor prescribed. This is also the case with Florida

### **Summary of Injection Drug Use Risk Reduction**

Individuals may reduce their risk of HIV from unsafe practices by:

- ☐ Abstaining from injecting drugs
- ☐ Abstaining from sharing needles, syringes, cookers, and other injecting equipment
- ☐ Cleaning used needles and syringes three times with bleach and rinsing with water three times.

#### **H. Non-Injection Drug Use**

Using illicit drugs and/or abusing prescription drugs does not necessarily put people at risk for HIV directly; however, the behavior that may accompany the drug use does. For instance, trading sex for drugs or for money to buy drugs increases the number of sexual partners and the risk of infection. Similarly, heavy alcohol consumption may cause a person to lose inhibitions and engage in unprotected sexual contact with an infected person and transmission could occur. Judgment is often impaired during inebriation and any measures to prevent the transmission of HIV by the individual may be compromised.

#### **I. Universal Precautions**

The risk of infection from a needle stick with HIV-infected blood is about 1 in 350, while the risk of HIV infection through exposure to mucous membranes is less than 1 in 1,000. As a result of these occupational risks, all health care workers are required to undergo training in basic infection control measures, also known as universal precautions. The observation of universal precautions involves the assumption that any patient could be infected with HIV and/or hepatitis and it is the responsibility of health care workers to take appropriate precautions to protect themselves and their patients. Proper attention to universal precautions at all times will reduce the likelihood of infection transmission in health care settings.

Universal precautions include such practices as hand washing, the use of protective barriers, proper disposal of needles, and cleaning and disinfecting spills. Health care workers must take precautions when working with the body fluids of others. Hands should be washed properly and frequently. Latex or plastic gloves, goggles, masks, and protective aprons should be worn during

appropriate times and procedures to reduce the risk of exposure of skin and mucous membranes. The needles used for the injection of medicines or the drawing of blood should never be recapped or manipulated by hand in any way. All needles should be disposed of properly in puncture-proof containers. Some healthcare workers have reported contracting HIV through accidental needle sticks from recapping used needles. When cleaning and disinfecting spills, visible material should be removed with disposable towels and the area decontaminated with a 1:10 solution of bleach and water.

More information can be found on line from the 2007 Guidelines for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings

<http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>

Infection Control Guidelines from the US Occupational Safety and Health Administration

<http://www.osha.gov/SLTC/etools/hospital/hazards/univprec/univ.html>

### III. Special Circumstances

#### A. Perinatal Transmission

Not all babies born to HIV-positive mothers will acquire HIV. An infected woman may pass HIV to her unborn baby in utero or during the birth process as the fetus passes through the birth canal or after birth through breast feeding. Without any preventive measures being taken, approximately 25 percent of all babies born to infected mothers in the United States will also be infected. There are some preventive measures that an HIV infected mother can take, however, to reduce that risk to 2 percent or less.

Studies have shown that if an infected woman takes anti HIV medications during pregnancy and delivery and if the newborn also receives appropriate treatments for the first six weeks of life, the chances of HIV transmission occurring are reduced to less than 5 percent. The higher the mother's viral load during pregnancy, the greater the risk of transmission. Combination antiretroviral therapy is recommended for use during pregnancy regardless of the mother's viral load. Using combination therapy between 14 and 34 weeks in pregnancy can be helpful in reducing the viral load, which in turn helps reduce the risk of transmission to the fetus in utero and also during labor and birth.

The method of birth may also reduce transmission. Cesarean delivery rather than a vaginal one may further reduce her chances of infecting her child. The decision to deliver cesarean may be based on the mother's viral load. If the mother's viral load is less than 1,000 at the time of delivery, a cesarean delivery is not recommended because no evidence showing that elective cesarean section at that point will further reduce the risk of perinatal HIV transmission.

HIV can be transmitted from mother to infant through breast feeding. The risk of transmission from mother to child through breast feeding is present due to the high number of T-cells in breast milk. Without treatment, an estimated one of every seven infants breast fed by an HIV-positive mother becomes infected. If the mother does not want to feed her baby formula, another option is locating a milk bank (an organization that collects donated breast milk and distributes it). For more information, look for the Human Milk Banking Association of North America, Inc.

In summary, the risk of perinatal transmission can be greatly reduced by:

1. Taking combination therapy during pregnancy to reduce maternal viral load
2. Continue anti-HIV therapy during labor and birth to help protect the baby while it's exposed to HIV in blood and cervical secretions
3. Choosing the birth option that poses the least risk to both mother and baby – a normal vaginal birth or an elective cesarean section
4. Administering anti-HIV therapy to the newborn for up to six weeks after birth
5. Bottle-feeding formula or breast milk from a milk bank instead of breast feeding or bottle-feeding the baby the mother's own breast milk.

Virtually all infants born to HIV-infected mothers will test positive for antibodies to HIV. These are maternal antibodies that crossed the placenta and will disappear by the age of 18 months in uninfected infants. Direct viral testing using polymerase chain reaction (PCR) or a viral culture can clarify the baby's HIV status usually within one month of birth.

## B. Transfusions and Blood Products

Since March of 1985, all donated blood and blood products in the United States have undergone HIV testing. Those specimens that test positive for HIV are destroyed. This screening process has practically eliminated the risk of HIV from a transfusion. Since 2002, blood banks and plasma centers, started to

utilize a highly sensitive HIV test called nucleic acid amplification test (NAAT), which can detect HIV early in the infection process.

Blood and blood products are also tested for HIV-2. In addition, blood collection centers thoroughly screen donors before taking their blood. Donors are confidentially asked specific questions about risky behaviors. If the blood collection center decides that an individual may have engaged in risky behaviors, they may be asked to refrain from donating.

The combination of HIV tests the blood banks now use has greatly reduced the risk of becoming infected with HIV from a blood transfusion.

Current estimates are that fewer than 1 in 1,900,000 blood components are capable of transmitting HIV. In contrast, the chance of becoming infected through unprotected sex with an HIV-infected individual is much higher. Higher still is the chance of becoming infected through injecting drugs and sharing needles with an HIV-infected individual.

#### C. No Identified Risk

Since 1981, some of the cumulative US cases have been documented as unknown transmission risks. Most of these are people who were diagnosed after their death or from who risk information is unavailable.

The “no identified risk” transmission category includes individuals who, upon being interviewed, refused to disclose their risk behavior(s). Others in this category are individuals who had multiple heterosexual partners, and the source patient cannot be identified.

#### D. Casual Transmission

Casual contacts, such as shaking hands or hugging, do NOT transmit HIV. In addition, HIV cannot be transmitted via toilets, swimming pools, sharing eating or drinking utensils, or by insects such as mosquitoes. We know that in almost all reported cases, infection occurred either through sexual contact or direct blood-to-blood contact. Nearly every Floridian has probably had casual contact with an HIV-infected individual, yet no Floridian has become infected with HIV by this means.

In a study that lasted several years, the CDC observed households from across the country in which a person infected with HIV/AIDS was living with individuals who were not infected. In these households, items such as eating

utensils, towels, beds and clothes were shared. In no case was HIV transmitted to an uninfected member of the household, where sexual or direct blood-to- blood contact did not take place. The uninfected household members were often caregivers for the infected person.

HIV is not transmitted through kissing, shaking hands with or bumping into an infected person, nor through coughing or sneezing. HIV has been isolated in body fluids such as saliva, tears and urine, but the concentration of infected T- cells in these fluids is so low, they are not capable of transmitting HIV. No detectable levels of HIV have been isolated in sweat.

According to the American Public Health Association's Control of Communicable Diseases in Man, "Routine social or community contact with an HIV-infected person carries no risk of transmission."



# ***CHAPTER 3***

## ***HIV Counseling, Testing and Linkage (CTL)***

## **HIV COUNSELING, TESTING, and LINKAGE (CTL)**

### **HIV Prevention Counseling**

Since 1993, the Centers for Disease Control and Prevention (CDC) has recommended for HIV prevention counseling to be conducted with a client-centered approach aimed at personal risk reduction. Client-centered counseling helps counselors and clients identify and commit to a specific behavior change. This approach is different from collecting client responses to risk behavior on a checklist also known as “information dissemination” or “data collection”. Counseling sessions should be tailored to address the personal risk of the client rather than providing a predetermined set of information unrelated to the client’s situation or allowing the session to be distracted by the client’s additional issues unrelated to HIV (referrals can be made for these issues).

HIV prevention counseling is offered during pre-test and post-test counseling sessions. The primary goals of prevention counseling are to identify behaviors that may place the client or patient at risk for HIV infection and explore ways to reduce that risk. Counselors accomplish these goals through an in-depth personalized risk assessment and negotiation of an individualized plan that is concrete, acceptable, and achievable. Risk assessment is an essential element of HIV prevention counseling in which the client and counselor work to understand and acknowledge the client’s personal HIV risk(s); however, HIV testing is available to everyone regardless of risk.

In Florida, HIV testing is established and governed by section 381.004, Florida Statutes, Florida Administrative Code rule 64D-2.004, Internal Operating Procedures, and Model Protocols, all of which are in line with the HIV testing guidelines issued by the Centers for Disease Control and Prevention.

Florida law carefully structures how health care providers and other registered test sites may conduct HIV testing. The Model Protocols provide guidelines for performing HIV testing and counseling in accordance with statutory requirements and established public health policy.

For pregnant women, HIV testing, as well as testing for other sexually transmitted diseases is provided as a standard of care at the initial prenatal care visit and again at 28-32 weeks gestation. Prior to testing, practitioners shall notify the woman which tests will be conducted and of her right to refuse any and all tests. If the woman objects to testing, a written statement of objection specifying which tests were refused, signed by the woman, shall be placed in the woman’s medical record and no testing shall occur.

The “Revised Recommendations for HIV Screening of Adults, Adolescents, and Pregnant Women in Health-Care Settings” can be found on line at:

<http://www.phppo.cdc.gov/PHTN/webcast/HIV11-17-05/default.asp>

**Pre-test counseling** in the context of HIV prevention counseling is a continuation of the risk assessment that includes an assessment of the client’s knowledge of HIV/AIDS and clarification of misconceptions about transmission, an exploration of previous attempts to reduce risk, and identification of successes and challenges in previous risk reduction.

**Post-test counseling** occurs when test results are given regardless of the result. Information covered during the pre-test counseling session should be readdressed in the post-test counseling session. Counselors should link high-risk negative clients to a medical provider for PrEP assessment and initiation. Counselors should LINK clients who test positive to appropriate medical and partner services (PS) through the local county health department. Clients should be referred to other services as appropriate.

### **HIV Testing**

HIV antibody testing has been available since March of 1985. The original intent of the HIV antibody blood test was to screen the nation’s supply of donated blood and blood products. When the test first became available, some people went to blood collection centers to find out their HIV antibody status. Since the ability of the test to predict true infection was questionable at that time, the potential for people to donate infected blood even after getting through the screening process existed. As a result, Florida established HIV testing in county health departments, and later in community- based and faith-based organizations, other healthcare settings, mobile units, drug treatment centers, schools and universities, outreach settings, and during special events. Each county has an anonymous HIV test site within the county health department.

Test sites may or may not charge a nominal testing fee. Most county health departments use a sliding fee scale that is based on the client’s ability to pay.

Florida law requires that no person shall perform an HIV test in a non-health care setting without first obtaining and documenting informed consent. Exceptions include if the person being tested is not competent, is incapacitated, or is otherwise unable to make an informed judgment, in which case the legal guardian can give consent. Informed consent is also not required in health care settings or in situations of court-ordered testing.

Informed consent should include an explanation of confidentiality, the benefits and limitations, and reporting requirements for a positive confidential test. An individual may be tested either **confidentially** (personal and demographic information on the individual and their test result is kept in a confidential record) or **anonymously** (client-identifying information is neither recorded nor solicited).

### **Antibody Tests**

Most HIV tests currently performed in the United States are antibody tests. This testing procedure isolates the antibody to HIV and not the virus itself. Specimens of serum (blood), plasma, dried blood spots, oral mucosal transudate from the mouth, and urine can be used

to test for HIV antibodies. Urine antibody tests are seldom used in Florida.

### **Antigen Tests**

Antigen tests are tests that look directly for the presence of HIV by detecting HIV proteins or genetic RNA expression. These tests can be quantitative (think of them as counting the number of detected HIV) and are the viral load tests used for patient care purposes; or, they can be qualitative (think of them as determining Yes or No to the presence of HIV) and are used for HIV diagnostic or testing purposes.

PCR is an example of a diagnostic antigen test. PCR looks for HIV's specific outer coating proteins. Nucleic acid amplification tests (NAAT) have been approved to aid in the diagnosis of HIV infection and have become components in current HIV testing algorithms and procedures including in Florida.

According to Florida law, no test result shall be determined as positive, and no positive test result shall be revealed, without a corroborating or confirmatory test. Exceptions to this procedure involving the preliminary release of test results can be made when decisions about medical care or treatment cannot wait for the results of confirmatory testing, such as a pregnant woman about to give birth or a client exhibiting clinical symptoms of AIDS or in cases of rapid HIV testing.

### **Florida HIV Testing Technology and Algorithms as of 2012**

There are several HIV testing products used in Florida all of which are subject to change as HIV testing technology improves and becomes available to sites and to state and private labs. Current HIV testing technology includes: CLIA waived point-of-care rapid antibody screens; lab-based antibody screens; combination antibody/antigen screens; and, confirmation tests by Western Blot, non-waived rapid, and NAAT.

Only testing sites approved to perform rapid testing and with counselors certified to perform rapid testing can offer rapid tests to their clients. Rapid test sites are required to follow product manufacturer's instructions and Department rapid test guidelines. Because they

are screening tests, all reactive rapid test results must be confirmed with a lab-based test before the client can be determined HIV positive.

Most infected people will develop a detectable level of HIV antibodies within 21 - 90 days after exposure; exceptions to that are very rare. This time from infection with the virus until final antibody production is technically called seroconversion and often referred to as the window period. It is important to understand that HIV-infected individuals can transmit the virus during the window period.

In addition to screening and diagnosis for HIV infection, labs also offer PCR and other molecular testing, HIV genotyping and phenotyping, and HIV viral load testing.

### **Blood and Plasma Samples**

Blood and plasma samples sent to the state labs are screened with a “4<sup>th</sup> generation” antibody/antigen combination immunoassay (IA) test. If the screening IA is negative, the sample is reported as HIV antibody/antigen negative. If it is positive, the screen is run a second time. No matter the second result, the initial positive screen is confirmed with an antibody confirmation supplemental (Supp) test.

If the supplemental confirmation is positive, the sample is reported as HIV antibody positive. If the supplemental confirmation is negative, the sample reflexes to an antigen NAAT test.

If the NAAT confirmation is negative, the sample is reported as antibody/antigen negative. If the NAAT confirmation is positive, the sample is reported as NAAT antigen positive indicating acute or very early HIV infection.

### **Oral Samples Collected with an OraSure Collection Device and Dried Blood Spot Samples**

Oral and dried blood spot samples sent to the state labs are screened with a “3<sup>rd</sup> generation” enzyme-linked immuno assay antibody test (formally called ELISA and EIA, now called IA). If the screening IA is negative, the sample is reported as HIV antibody negative. If the screening IA is positive, the IA is run a second time. No matter the second IA result, the sample is confirmed with a Western blot antibody confirmation test.

Western blot can have three results. A sample with a negative Western blot is reported as HIV antibody negative. A sample with a positive Western blot is reported as HIV antibody positive. And, a sample with an indeterminate Western blot is reported as HIV antibody inconclusive. Clients or patients with an inconclusive HIV test must have a second sample submitted for confirmatory testing – blood samples which undergo the blood test algorithm, are strongly encouraged for follow up testing.

OraSure is an oral specimen collection device approved by the FDA in December 1994. The collection device draws antibodies out of the cheek and gum in oral mucosal transudate (OMT) cells. This device is **not** intended to collect saliva for testing. The individual being tested inserts the collection pad into their mouth between the lower cheek and gum, and gently rub back and forth until moist. After leaving the collection pad in the mouth for a minimum of two minutes and a maximum of five minutes, the pad is placed in the specimen vial and sent to the state laboratory or to OraSure Technologies, Inc., the company that makes the device, for testing

The OraSure collection device is highly accurate, provided sufficient time has passed for antibodies to form and the test is performed correctly. The administering of OraSure is restricted to individuals who have been trained. This antibody test is not FDA approved for children less than 13 years of age.

### **Rapid Tests and In-Home Technologies**

Point of care rapid HIV screening tests produce results quickly, in a matter of 1 - 40 minutes. There are three rapid HIV screening tests available in Florida as of 2018; namely OraQuick Advance, Sure Check, and Determine Combo. OraQuick, manufactured by OraSure Technologies, Inc., is approved for testing of oral, finger stick whole blood, venipuncture blood, and plasma samples. Sure Check, manufactured by Abbott, Insti and Determine Combo manufactured by Alere are all approved for the screening of finger stick and venous whole blood specimens as well as plasma, though plasma specimens are not approved (waived) for testing outside of specially licensed laboratories.

Reactive rapid test results suggest that HIV antibodies are present in a sample and it is likely that the client or patient is HIV infected. A confirmatory sample, either from blood or plasma or an OraSure device, must be collected for confirmatory testing. Only lab-based results - supplemental, western blot or NAAT - are considered confirmatory.

Those who wish to collect a test sample in the privacy of their home and mail it to a lab for testing can utilize technology provided by Home Access. This product provides a safety lancet and collection card to capture blood. After the blood has dried, the user mails the collection card to the manufacturing company. Home Access uses an authorized laboratory to test for HIV antibodies and notifies customers of test results through a unique number on the collection card.

In 2012, the FDA approved the use of OraQuick oral HIV screening in the privacy of a client's home. The home use OraQuick is the same test that has been used by health care

professionals since 2004. The home kit contains instructions, the test kit, and information regarding confirmation testing and accessing counseling and services.

### **Test Results**

A **negative** HIV antibody test result usually indicates either that no infection is present or that the tested individual has recently been infected and has not yet developed a sufficient amount of HIV antibodies to be detected. Remember, it may take weeks to months after infection before enough antibodies are in the bloodstream to trigger an antibody test. It is rare for clients to seroconvert beyond 3 months after exposure.

A **reactive** HIV antibody test result usually indicates that the individual is infected and is capable of infecting others. **False positive results** are extremely rare. However, re-testing is required. A blood draw sent to the state lab should be administered to determine the HIV test result.

With the introduction of 4<sup>th</sup> generation technology indeterminate test results have become a thing of the past with blood-based testing. If a person is testing with OraSure and receives an indeterminate Western Blot, the individual should be encouraged to repeat testing immediately using a blood specimen sent to the state lab as the person may be in the process of seroconversion.

A **positive NAAT** test result indicates that HIV RNA expression has been detected. The reporting of a positive NAAT also rests on what the lab calls the signal-to-cut-off (s/co) ratios. If the signal-to-cut-off is sufficient, the sample is reported as HIV antigen positive even if the antibody supplemental test is negative. Because clients or patients with a positive NAAT are very early in their infection process and because they are considered highly infectious with HIV, response to the test result must be swift. These reports go directly to the HIV and STD programs in Tallahassee and the county health department STD office.

### **Other Testing Associated With HIV Infection and an AIDS Diagnosis**

Doctors will order additional tests when an individual is post-test counseled and informed they are HIV positive. These tests may include: viral load, CD4 and T4/T8 Ratio to see how much HIV is detectable and assess disease progression; complete blood cell count (CBC) to determine overall status of the blood and immune system; RPR for syphilis, one of the common STDs transmitted with HIV; pregnancy, and/or liver and renal function profiles.

## **Viral Load Testing**

Viral load testing is used by health care providers to determine when to start antiretroviral therapy and when to change current therapies. Viral load is the quantity of HIV detected in a sample of blood. Studies have shown that knowing the viral load is important in the management of HIV infection, and serves as a predictor of disease progression and the strength of the immune system.

There are different viral load tests currently being used and, because the tests do not give exactly the same results, it is important to have the same type of test done each time. Results of the test should be interpreted in the context of clinical management by an experienced physician. Viral load measuring should be avoided in the 3-4 weeks following an immunization (including flu shots) or within one month of an infection, to minimize misleading results.

With ongoing monitoring of viral load, it is important to monitor CD4+ levels. CD4+ levels provide information about the status of the immune system and are used to determine if someone meets the definition of AIDS, which is characterized by a CD4 level of 200 per mm<sup>3</sup> or lower.

Sometimes a person with HIV infection may have the virus “undetectable” in a viral load test. This does not mean the person is no longer infected; it means that the amount of virus in the bloodstream is below testing threshold.

## **Partner Services (PS)**

Partner Services (PS) is the process by which sexual and/or needle-sharing partners of HIV-positive clients are identified, located, and informed of their possible exposure to HIV. PS is a very effective HIV prevention strategy. There are three methods of follow-up of partners used by the Florida Department of Health:

1. Client Referral: The HIV-infected individual chooses to inform their partners themselves and refer those partners for HIV counseling and testing.
2. CHD Referral: The HIV-infected individual consents to having the CHD STD Program take responsibility for contacting the partners and referring them to HIV counseling and testing, and other services (the identity of the HIV-positive person is highly protected).
3. Contract Referral: CHD STD Program does the informing of partners only if the client does not notify the partner within a negotiated time period.

Due to the sensitive nature involved in the identification and location of partners, PS should be performed by an HIV counselor who is trained in these techniques. Pursuant to section 384.26, F.S., only the Department of Health may conduct PS. The CHD STD program is responsible for all PS activities, regardless of where the client was originally

tested. Other CHD staff may elicit information regarding partners, but only STD Disease Intervention Specialists (DIS) may perform notification of partners. Each test site should establish and maintain good rapport with their local CHD STD Program to facilitate the provision of PS to clients who test positive.

### **Referrals and Linkages**

Referral and/or linkage services should be offered to all clients of HIV test sites who are in need of medical, prevention, and other supportive services, particularly clients who are HIV positive. Extra efforts should be made to link HIV-positive clients to appropriate medical services because such services increase the likelihood of maintaining health, enhancing longevity and quality of life, and reducing the risk of transmission. Reasonable efforts should be made to refer high-risk HIV-negative clients to appropriate and available prevention and other supportive services including PrEP, to reduce the likelihood of these clients acquiring HIV.

Linkages differ from referrals because linkages require providers to take whatever steps are necessary to ensure service access. This may mean that the provider makes a phone call to a referral agency to make an appointment for the client and then calls the referral agency to ensure that the appointment was kept. The provider could also give the client a linkage form with the address and phone number of the referral agency and a specific contact person of that agency who can then send a copy of the referral form back to the provider with documentation that services were/are being provided to the client. Counselors should provide assistance in accessing and completing linkage and referrals, and verify completion.



# ***CHAPTER 4***

## ***Infectious Diseases***

## INTRODUCTION TO INFECTIOUS DISEASES

Like HIV, sexually transmitted diseases (STD) also called sexually transmitted infections (STIs) are contracted principally through sexual intercourse. This unit will focus on various infectious diseases that HIV prevention counselors are likely to encounter while working with clients with or at risk for HIV. Because of the established links between many of these diseases and HIV infection, high co-morbidity rates, and overlapping risk factors, HIV prevention counselors should become familiar with the signs and symptoms, modes of transmission, and risk factors associated with each of the diseases.

Although there are millions of microbes capable of causing disease, the bacteria and viruses most applicable to the HIV prevention counselor are ones transmitted from person to person, including those causing STDs, TB, and viral hepatitis. These diseases are referred to as HIV co-factors. A co-factor is something that may assist with transmission and speed up disease processes. Through increased knowledge of these diseases, the HIV prevention counselor will better be able to assist clients in decreasing the risk of acquiring disease, prevent further transmission if infected, and reduce the chances of complications through referral and linkage to an appropriate health care professional.

## **Sexually Transmitted Diseases (STDs)**

Sexually Transmitted Diseases (STDs) are infections that are transmitted from one person to another during vaginal, anal, and oral sex. The CDC estimates that 19 million new cases of STD occur annually, with a direct medical cost of 13 billion dollars. In addition, STDs are the most common infectious diseases in the United States.

Over 20 STDs have been identified. Some of the more common ones include Chlamydia, gonorrhea, syphilis, genital herpes, human papillomavirus (genital warts), and trichomoniasis. HIV and hepatitis A, B, and C are examples of sexually transmitted diseases as well, but also have additional modes of transmission.

## **Signs and Symptoms**

Typical signs and symptoms of STDs include a discharge from the penis or vagina, pain upon urination (more often men), lower abdominal pain (women), and lesions or blisters on or around the genital area. Unfortunately, STDs are often asymptomatic (no detectable symptoms). Even when an STD causes no symptoms, a person who is infected is able to pass the disease on to their sex partner(s). In addition, more than one STD can be present and passed on at the same time.

## **Treatment**

Some STDs can be treated and cured with antibiotics. For others, such as herpes and HIV/AIDS, there is no cure, but there are medications available to assist in managing the disease. Treatment of STDs can also be an effective tool in preventing the spread of HIV. Treating STDs in HIV infected individuals decreases both the amount and how often HIV is shed and decrease the ability to transmit HIV. Detecting and treating STDs can substantially reduce HIV transmission at the individual and community levels.

## **Complications**

If left untreated, STDs can cause serious medical problems like infertility, cardiovascular and neurological disorders, birth defects, and even death.

## **The Established Link Between STDs and HIV Infection**

- **Increased susceptibility:** STDs may increase susceptibility to HIV infection. Genital ulcers caused by syphilis, herpes or chancroid, result in breaks in the genital tract lining or skin create portals of the entry for HIV. Non-ulcerative STDs, such

as Chlamydia, gonorrhea, and trichomoniasis, increase the concentration of immune cells in genital secretions that can serve as targets for HIV.

- **Increased infectiousness:** Evidence suggests that STD infected individuals are at least two to five times more likely than uninfected individuals to acquire HIV if they are exposed to the virus through sexual contact. In addition, HIV infected individuals who also have an STD are more likely to transmit HIV through sexual contact than someone who is HIV negative. Individuals infected with other STDs are more likely to have HIV in their genital secretions. For example, men who are infected with both gonorrhea and HIV are more than twice as likely to shed HIV in their genital secretions as are those who are infected only with HIV. Moreover, the median concentration of HIV in semen is as much as ten times higher in men who are infected with both gonorrhea and HIV than in men infected only with HIV

### **Partners Need to be Notified**

Whether it's a bacterial disease such Chlamydia, gonorrhea or syphilis that can be cured with medication or a viral STD like HIV, Herpes or HPV, infected individuals should ensure their partners are notified of their exposure and receive appropriate treatment. Future partners can be protected from some STD infections by informing them before having sex and by the proper and consistent use of condoms.

### **STD Clinical Services in Florida**

Clinical services are provided in strict confidentiality and are available to all who seek care for early intervention and treatment of STDs. Adults, adolescents and immigrants can all receive STD clinical services at any of the 67 county health departments at reasonable cost or no cost. Florida law assures adolescents confidential STD clinical services.

Clinical services for STDs include risk assessment, physical examination, numerous STD tests, treatment and counseling.

If a person is symptomatic during the visit and the clinic doctor or nurse practitioner determines it is a STD, treatment is provided or a prescription is written to purchase medications at a pharmacy. Trained counselors talk with clients about reducing their risk for getting STDs and how to prevent infections from spreading to their partner(s).

STD	SYMPTOMS		WHAT HAPPENS IF YOU DON'T GET TREATED
CHLAMYDIA	Symptoms may show up 7-21 days after having sex. Most women and some men have no symptoms.		<p>YOU CAN GIVE CHLAMYDIA TO YOUR SEXUAL PARTNER(S).</p> <p>Untreated, may lead to more serious infections such as Pelvic Inflammatory Disease 10-15% of the time. Reproductive organs can be damaged. Both men and women may no longer be able to have children. A mother with Chlamydia can give it to her baby during childbirth.</p>
	<p><b>WOMEN:</b> Discharge from the vagina. Bleeding from the vagina between periods. Burning or pain when you urinate (pee). Pain in abdomen (belly), sometimes with fever and nausea.</p>	<p><b>MEN:</b> Watery, white drip from the penis. Burning or pain when you urinate (pee).</p>	
GONORRHEA (clap, drip, GC)	Symptoms show up 2-21 days after having sex; 1-14 days for men. Most women and many men have no symptoms		<p>YOU CAN GIVE GONORRHEA TO YOUR SEXUAL PARTNER(S).</p> <p>May lead to more serious infection. Reproductive organs can be damaged. Both men and women may no longer be able to have children. A mother with gonorrhea can give it to her baby during childbirth. Can cause heart trouble, skin disease, arthritis and blindness.</p>

STD	SYMPTOMS		WHAT HAPPENS IF YOU DON'T GET TREATED
GONORRHEA (continued)	<p>WOMEN: Thick yellow or white discharge from the vagina. Burning or pain when you urinate (pee) or have a bowel movement. More pain than usual during periods. Cramps and pain in the lower abdomen.</p>	<p>MEN: Thick yellow or white drip from the penis. Burning or pain when you urinate (pee) or have a bowel movement.</p>	
SYPHILIS (syph, the pox)	<p>1st STAGE: Symptoms show up 1-12 weeks (average of 21 days) after having sex usually as a chancre ( reddish-brown sore) lasting lasts 3-6 weeks. It goes away, but will progress to secondary stage.</p>		<p>YOU CAN GIVE SYPHILIS TO YOUR PARTNER(S).</p> <p>Individuals in primary syphilis are highly infectious. A mother with syphilis can give it to her baby during childbirth. May cause heart disease, brain damage, blindness, and death.</p>

STD	SYMPTOMS	WHAT HAPPENS IF YOU DON'T GET TREATED
<p>SYPHILIS (continued)</p>	<p>Secondary Stage: Symptoms 2-10 weeks after sore appears, rash forms anywhere on the body. Flu- like feelings. Sore, rash and flu-like feelings go away, but will progress to Late Stage syphilis.</p>	
<p>SYPHILIS (continued)</p>	<p>Latent Stage:  Begins when primary and secondary symptoms disappeared. Most of the time there are no symptoms.</p>	<p>The late stages develop in about 15% of the people who have not been treated and can appear 10-20 years after the infection was first acquired. In the late stages, syphilis may damage internal organs, brain, nerves, eyes, heart, blood vessels, liver, bones and joints. Signs and symptoms include difficulty with muscle movements, paralysis, numbness, gradual blindness, and dementia. Death may result.</p>
<p>GENITAL WARTS  Human Papillomavirus (HPV)</p>	<p>Symptoms show up 1-6 Months or more after having sex. Small, bumpy warts on sex organs and anus. The warts do not go away. Itching and burning around sex organs</p>	<p>YOU CAN GIVE GENITAL WARTS TO YOUR SEXUAL PARTNER(S).</p> <p>More warts grow and are harder to get rid of. A mother with warts can give them to her baby during childbirth. HPV may lead to precancerous conditions of the cervix.</p>
<p>HERPES</p>	<p>Symptoms show up 2-30 days after having sex. Most women and many men have no symptoms. Flu-like feelings. Small, painful blisters on the sex organs or mouth. Itching or burning before the blisters appear. Blisters last 1-3 weeks. Blisters go away, but you still have herpes. Blisters can come back.</p>	<p>YOU CAN GIVE HERPES TO YOUR SEXUAL PARTNER(S).</p> <p>Spread during sexual intercourse, oral sex and anal sex with someone who has herpes. There may be 4-5 occurrences the first year, but overtime, the frequency may decrease.</p>

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[WWW.CDC.Gov](http://WWW.CDC.Gov)

[WWW.ASHASTD.org](http://WWW.ASHASTD.org)

**Hotline:** National STD Hotline: (800) 227-8922

## **Hepatitis**

Viral hepatitis includes three diseases, **hepatitis A**, **hepatitis B**, and **hepatitis C**, each of which is very important to people at risk for HIV, those infected with HIV, and those living with AIDS. The risk factors for infection with the hepatitis viruses are similar to the risk factors for HIV infection. In addition, persons infected with HIV tend to experience the more severe consequences of hepatitis infection. This chapter can help you provide hepatitis information to your clients, many of whom can benefit from HIV and hepatitis counseling. There is no requirement that you provide extensive hepatitis services. The information contained in this chapter is for your information and reference only, and is provided here as a convenient resource for you and your clients.

## **What is Hepatitis?**

Hepatitis is a general term for different illnesses, all of which cause the same problem: an inflamed liver. Hepatitis can be caused by toxins such as alcohol and environmental pollutants or any one of the hepatitis viruses, including hepatitis A, B, and C. Constant exposure to these toxins or viruses causes liver cells to die and be replaced by scar tissue. This scarring of the liver is commonly known as cirrhosis. When liver cells die, they stop performing vital life functions, causing problems with the proper digestion of food, the ability to produce clotting factors and proteins, the ability to build muscle or to filter out harmful pathogens, toxins, and poisons. Symptoms associated with hepatitis may include jaundice, dark urine, light stool, fever, nausea, vomiting, fatigue, abdominal pain, and anorexia.

For additional information about viral hepatitis, clinical trials, and support groups, please visit our Internet website, <http://www.floridahealth.gov/diseases-and-conditions/hepatitis/> or [www.cdc.gov/hepatitis](http://www.cdc.gov/hepatitis).

## **Basic Terminology**

<b>Term</b>	<b>Meaning</b>
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
IgM	Immunoglobulin M
HBIG	Hepatitis B immune globulin
HBsAg	Hepatitis B surface antigen
Anti-HBc	Antibody to hepatitis B core antigen

<b>Term</b>	<b>Meaning</b>
Anti-HBe	Antibody to hepatitis B e antigen
Anti-HBs	Antibody to hepatitis B surface antigen
IG	Immune globulin
LFT	Liver function test
ALT	Alanine transaminase
ELISA or EIA	Enzyme-Linked Immunosorbent Assay
RIBA	Recombinant Immunoblot Assay
Bilirubin	Product of broken down hemoglobin that turns skin jaundice (yellow), when liver function deteriorates
Acute Infection	Discrete onset of symptoms with an infection that lasts for 6 months or less
Chronic Infection	Infection lasts throughout one's lifetime, virus remains in the body, and is able to be transmitted to others
Incubation Period	Time from initial infection to the onset of symptoms

## **Hepatitis A**

Hepatitis A is a virus that causes inflammation of the liver. There is no chronic infection associated with hepatitis A.

### **Modes of Transmission**

Hepatitis A is found in feces and in the intestinal tract, and can be spread by:

- ☐ Eating contaminated food prepared by an infected person who did not wash their hands properly
- ☐ Having anal/oral sex
- ☐ Eating contaminated shellfish
- ☐ Drinking contaminated water.

The hepatitis A virus is rarely transmitted via the blood borne route, and is never transmitted through the air or by casual contact such as coughing, sneezing or being in the same area as an infected person.

The virus can be spread to others 2 weeks prior to jaundice. However, infectivity decreases soon after symptoms begin.

## **Symptoms**

The incubation period for hepatitis A is 15 to 50 days, with an average of 28 days.

While children who contract hepatitis A usually have no symptoms, adults usually become very ill and display the common hepatitis symptoms described in this section.

## **Testing**

Tests commonly performed to diagnose hepatitis A include:

- ☐ **IgM anti-HAV (IgM hepatitis A antibody):** if a patient tests positive, they have acquired the hepatitis A virus or have been vaccinated within the last six months.
- ☐ **Anti-HAV total (hepatitis A antibody total):** appears as the person convalesces, and gives protection against future infection.

## **Who is at risk?**

Although anyone can be infected with HAV, some people are at a greater risk. These would include:

- ☐ Persons traveling to areas where HAV is common
- ☐ Persons who have had sexual contact with someone who has HAV
- MSM
- Household members or caregivers of a person infected with HAV
- Persons using injection and non-injection illicit drugs

## **Hepatitis A Positive Persons**

Persons that test positive for hepatitis A should be counseled to:

- ☐ Use proper hygiene techniques, including washing hands with warm soapy water after bowel movements and diaper changing, and the disinfection of areas where fecal residue may be present.
- ☐ Get plenty of rest.
- ☐ Avoid alcohol consumption.
- ☐ Get vaccinated against hepatitis B (if they have a risk for hepatitis B -see hepatitis B section).

- ☐ Identify exposed contacts so that they can be given IG and vaccine within 14 days of exposure.
- ☐ Discuss all medications, including over-the-counter, with their physician.
- ☐ Eat well balanced, low fat meals, and avoid high protein intake.
- ☐ Understand the modes of transmission for hepatitis A.

### **Hepatitis A Negative Persons**

Persons that test negative for hepatitis A should be counseled to avoid activity that will put them at risk for contracting the virus. These prevention measures include:

- ☐ Proper hygiene techniques, including washing hands with warm soapy water after bowel movements and diaper changing, and the disinfection of areas where fecal residue may be present
- ☐ Hepatitis A vaccination for those persons at high risk
- ☐ Vaccination for those persons with compromised immune systems or certain chronic diseases, such as HIV/AIDS or chronic hepatitis C
- ☐ Avoiding unprotected sexual practices that involve anal-oral and fecal-oral contact
- ☐ Avoiding consumption of raw shellfish

### **Vaccination and Prophylaxis**

Hepatitis A vaccination is recommended for:

- ☐ All children at age 1 year
- ☐ Travelers to countries where HAV is common
- ☐ Men who have sex with men
- ☐ Users of recreational drugs
- ☐ Persons with clotting factor disorders
- ☐ Persons with chronic liver disease, chronic HBV or HCV
- ☐ Person with compromised immune systems (e.g., HIV/AIDS).

There are two types of products available for prophylaxis and prevention of hepatitis A infection:

- ☐ **Hepatitis A vaccine** provides active immunity against the hepatitis A virus through a series of two injections, with the second given at 6 months after the first. The vaccine can provide protection as soon as four weeks after the first injection. The second injection can provide immunity for possibly 25 years in adults.
- ☐ **Immune Globulin (IG)** provides protection against HAV through passive transfer of antibodies. IG provides temporary immunity to the virus for 2-3 months, if administered prior to exposure or within 2 weeks after exposure.

### **Treatment**

There is no specific treatment for HAV, only the management of symptoms. The infection will clear up within a couple of months, and the patient will be immune to the virus.

## **Hepatitis B**

Hepatitis B is found in blood, seminal fluids, vaginal secretions, and other body fluids. The virus can be spread by:

- ❑ Unprotected sexual contact with an infected person, especially among persons with multiple sex partners or men who have sex with men (MSM)
- ❑ Contact with contaminated needles, especially injection drug equipment. Other items such as tattoo and body piercing instruments, razors, and toothbrushes may be contaminated with infected blood.
- ❑ An infected mother to her infant during delivery
- ❑ Household contact with an infected person
- ❑ Occupational exposure through accidental needle stick.

HBV is not an airborne virus, and is never transmitted through casual contact such as coughing, sneezing, being in the same area as an infected person or by consuming contaminated food or water.

## **Symptoms**

The incubation period for hepatitis B is 6 to 24 weeks, with an average of 8 to 12 weeks. The majority of persons infected with acute HBV are asymptomatic.

## **Chronic Hepatitis B**

Chronic hepatitis B refers to an infection where the body is not able to eliminate the virus. About 90 percent of those infected by HBV as children and 10 percent of those infected as adults will develop chronic infection, which may lead to cirrhosis and cancer of the liver. Patients that develop severe liver damage may need to undergo liver transplant surgery to replace the damaged liver with a healthy one. **People with chronic hepatitis B remain infectious throughout their lifetime, unless successfully treated.**

## **Testing**

Hepatitis B status can be determined using results of several commonly ordered tests.

- HBsAg = Hepatitis B surface antigen
  - ❖ Indicates acute infection or a carrier of hepatitis B and infectious to others
- HBsAb = Hepatitis B surface antibody
  - ❖ Indicates immunity to hepatitis B from exposure to the virus or from vaccination
- Anti-HBc = Total Hepatitis B core antibody
  - ❖ Indicates that the person has or had hepatitis B. It does not develop after immunization with Hep B vaccine

## **Counseling**

There are certain populations and behaviors that are more likely to put someone at risk of becoming infected with hepatitis B virus or to experience the severe consequences of the disease. Individuals at risk that should be offered counseling, education, and testing include:

- ☐ Sexually active persons, especially with multiple sex partners
- ☐ Injection drug users
- ☐ Men who have sex with men (MSM)
- ☐ Health care workers whose occupation exposes them to blood
- ☐ Infants born to infected mothers
- ☐ Household contact with an infected person
- ☐ Hemodialysis patients.

### **Hepatitis B Positive Persons**

Persons who test positive for hepatitis B should be counseled to:

- ☐ Avoid having unprotected sex
- ☐ Avoid sharing injection drug equipment
- ☐ Avoid alcohol consumption
- ☐ Get vaccinated against hepatitis A
- ☐ Identify sexual and other contacts so they can be given HBIG and vaccine
- ☐ Seek medical care
- ☐ Eat well balanced, low fat meals, and avoid high protein intake
- ☐ Understand the modes of transmission for hepatitis B.

Patients should also be given education about the two possible courses of the disease.

Infected persons may:

- ☐ **Become chronically infected:** Approximately 80–90 percent of those infected as infants, 30 percent of those infected as children under 5 years of age, and 6 percent of those infected at greater than 5 years of age will become chronically infected, meaning that the virus is not cleared from the body. The virus remains in the blood and body fluids, therefore, the person can spread the virus to others.
- ☐ **Develop immunity:** Approximately 90 percent of those infected as adults and 10 percent of those infected as children will clear the virus from their body and will develop immunity to hepatitis B infection.

### **Persons Having an Indeterminate Test for Hepatitis B**

Persons whose test results are indeterminate for hepatitis B should be counseled to:

- ☐ Retest in 6 months or sooner if symptoms develop.
- ☐ Get vaccinated for hepatitis A vaccine
- ☐ Avoid all activities that can transmit hepatitis B.
- ☐ Understand the modes of transmission for hepatitis B.

### **Hepatitis B Negative Persons**

Persons who test negative for hepatitis B should be counseled to use appropriate prevention measures to avoid contracting the virus. These prevention measures include:

- ☐ Vaccination for persons at risk
- ☐ Refraining from unprotected oral, vaginal and anal intercourse
- ☐ Avoiding using objects that may have infected blood on them
- ☐ Using standard precautions for occupations which involve possible exposure to blood
- ☐ Understanding the modes of transmission for hepatitis B.

### **Vaccination and Prophylaxis**

Hepatitis B vaccination is recommended for:

- ☐ Children 0 – 18 years of age
- ☐ Men who have sex with men
- ☐ Sexually active persons with multiple sex partners
- ☐ Persons who have ever used injecting drugs
- ☐ Household and sex contacts of HBV positive persons
- ☐ Persons with compromised immune systems
- ☐ Persons with chronic liver disease or chronic hepatitis C
- Inmates of long-term correctional facilities

There are two types of products available for prophylaxis and the prevention of hepatitis B infection:

- ☐ **Hepatitis B vaccine** provides long-term protection against HBV infection, and is used for both pre-exposure and post-exposure prophylaxis. There are three doses of the vaccine; the second dose is given 1 month after the first, and the third dose is given 6 months after the first.
- ☐ **Hepatitis B Immune Globulin (HBIG)** provides temporary protection against the hepatitis B virus for 3–6 months, and is used only in certain post exposure settings.

### **Treatment**

There are medications available to treat **chronic** hepatitis B.

- Not everyone who is infected with the hepatitis B virus needs treatment
- Doctors generally recommend treatment only if the virus is damaging the liver

### **Pregnancy and Perinatal Issues**

Pregnant women who have HBV can pass it to their baby during delivery. Without any intervention, 85–90 percent of the babies born to hepatitis B positive mothers will become chronically infected with the virus.

### **Screening**

- ☐ All pregnant women should be tested for hepatitis B, which should be done at the same time as other prenatal tests.
- ☐ If a woman tests positive (has HBsAg in her blood), the newborn should receive HBIG along with the hepatitis B vaccine.

### **Vaccination**

- ☐ All newborns born to a hepatitis B positive mother must receive HBIG and the first dose of the hepatitis B vaccine within 12 hours of birth.
- ☐ The second dose is given 1-month after the first dose, and the third dose is given at 6 months after the first.
- ☐ The infants should be tested for immunity, upon completion of the vaccine series.

**NOTE:** As part of routine childhood vaccinations, it is recommended that all infants be immunized against hepatitis B starting at birth, regardless of mother's hepatitis B status. However, this routine immunization series does not include the dose of HBIG.

### **Breastfeeding**

- ☐ Women with hepatitis B can breastfeed, provided that the baby receives HBIG and the first dose of the vaccine within 12 hours of birth, and receives the other two doses of the vaccine on schedule.

## **Hepatitis C**

Hepatitis C is an inflammatory liver disease caused by the hepatitis C virus. In 1988, hepatitis C was discovered to be the primary cause of non-A and non-B hepatitis. Prior to 1992, there was no adequate test implemented for the detection of specific hepatitis C antibodies. There are acute and chronic infections associated with hepatitis C. Chronic hepatitis C can lead to cirrhosis and liver cancer.

### **Modes of Transmission**

Hepatitis C is found in blood, and can be spread by:

- ☐ Sharing injection drug equipment
- ☐ Having a blood transfusion or organ transplant before 1992
- ☐ Receiving clotting factor concentrates before 1987
- ☐ An infected mother to her infant during delivery
- ☐ Occupational exposure through needle stick
- ☐ Sexual contact (infrequent).

### **Symptoms**

The incubation period can vary from 2 to 26 weeks, with an average between 6 to 9 weeks.

### **Acute Hepatitis C**

People who are infected with hepatitis C are usually asymptomatic. However, if a patient has acute hepatitis C, symptoms may include those listed at the beginning of this section

### **Chronic Hepatitis C**

Chronic hepatitis C refers to an infection where the body is not able to eliminate the virus. Most of those infected are asymptomatic and it may take 10-30 years from the original time of infection to recognize chronic hepatitis C, about 20 years to recognize cirrhosis, and 30 or more years to recognize liver cancer.

### **Testing**

Hepatitis C status can be determined using results of several commonly ordered tests.

- Serologic screening test
    - ❖ Test for antibody
    - ❖ If it's negative, stop
    - ❖ If it's positive, confirmatory test is indicated
  - Confirmatory test
    - ❖ Viral detection test (NAT for HCV RNA)\*
- \*NAT: Nucleic acid testing  
\*RNA: Ribonucleic acid

## **Counseling**

There are certain populations and behaviors that are more likely to become exposed to the hepatitis C virus or to experience the severe consequences of the disease. Those in the following groups should be offered counseling, education, and testing:

- Any baby boomers born between 1945-1965
- Anyone who has ever used needles to inject drugs (even once)
- Persons who received clotting factors produced prior to 1987
- Persons on long term hemodialysis
- Persons who received a blood transfusion or organ transplant prior to 1992
- Persons with tests that show elevated liver enzymes
- Persons with a history of tattooing or body piercing in non-professional settings
- Infants born to infected mothers
- Persons who experience an occupational needle-stick

## **Hepatitis C Positive Persons**

Persons that test positive for hepatitis C should be counseled to:

- ☐ Avoid sharing needles and other activities that could transmit the virus
- ☐ Avoid alcohol consumption
- ☐ Be vaccinated against hepatitis A and hepatitis B
- ☐ Consult with a physician before taking any new medications
- ☐ Maintain a diet of well-balanced, low fat meals, and avoid high protein meals
- ☐ Seek medical care
- ☐ Identify exposed contacts so they can be tested and counseled for hepatitis C
- ☐ Understand the modes of transmission for hepatitis C.

## **Persons Having an Indeterminate Test for Hepatitis C**

Persons whose test results are indeterminate for hepatitis C should be counseled to:

- ☐ Retest in 6 months or sooner if symptoms develop
- ☐ Receive hepatitis A and B vaccine
- ☐ Avoid activities that can transmit hepatitis C
- ☐ Understand the modes of transmission for hepatitis C.

## **Counseling for Hepatitis C Negative Persons**

Persons that test negative for hepatitis C should be counseled to avoid activity that will put them at risk for contracting the virus. These prevention measures include:

- ☐ Avoid sharing injection drug equipment
- ☐ Avoid use of objects that may have infected blood on them, i.e., injection drug equipment, body/tattooing equipment, toothbrushes, and razors
- ☐ Follow standard procedures for occupations which involve exposure to blood
- ☐ Understand the modes of transmission for hepatitis C.

## **Vaccination and Prophylaxis**

There is no vaccine currently available for the hepatitis C virus.

## **Treatment**

Treatment options for hepatitis C are determined by blood test, biopsy results, and other factors, and are not based solely on the presence of symptoms, since the disease is typically asymptomatic.

To learn about the latest and most current treatments for hepatitis C, visit the HCV Advocate's Hepatitis C Treatment Page: <http://hcvadvocate.org/hepatitis/treatment.asp>

This page includes information about the current drugs to treat hepatitis C, how to manage the side effects of the drugs and other information related to treatment. It also includes comprehensive guides, HCV medication package prescribing information and guidance from medical societies.

## **Pregnancy and Perinatal Issues**

## **Transmission through Breast Milk**

HCV is not transmitted through breast milk.

## **HCV/HIV Co-Infection**

HCV/HIV Co-Infection means a person is infected with both the Hepatitis C virus (HCV) and Human Immunodeficiency Virus (HIV). There are an estimated 400,000 persons co-infected with HCV/HIV in the United States. Injecting drug use seems to increase the risk of co-infection. It's estimated that 70–90 percent of people who contracted HIV from injecting drug use also have HCV.

## **HCV/HIV Similarities**

- ☐ High levels of viral replication
- ☐ Cause of chronic infection that can persist for many years
- ☐ Most people do not experience symptoms early in the course of infection.

## **How Do HCV and HIV Affect One Another?**

Because HIV diminishes the ability of the immune system to fight off infection, it speeds up the rate of liver damage caused by HCV. This places the co-infected patient at a greater risk for cirrhosis, liver cancer, and liver failure than persons infected with HCV alone.

One of the functions of the liver is to process medications. It is very important that patients co-infected with HCV/HIV are aware of how to take care of their livers.

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## **Tuberculosis**

Tuberculosis (TB) is a disease caused by bacteria called *Mycobacterium tuberculosis*. TB is spread from person to person through the air and usually attacks the lungs. The bacteria are put into the air when a person with TB disease coughs or sneezes. People nearby breathe in these bacteria and become infected. TB can also move from the lungs, through the blood to other parts of the body, such as the kidney, spine, and brain.

## **Signs and Symptoms**

General symptoms of TB include feeling weak or sick, weight loss, fever, and/or night sweats. Symptoms of TB of the lungs may include cough, chest pain, and/or coughing up blood. Other symptoms depend on the particular part of the body that is affected. People who are infected with latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB. But they may develop TB disease at some time in the future. A person can have latent TB infection for years without any signs of disease. But if that person's immune system gets weak, the infection can quickly turn into TB disease. Also, if a person who has a weak immune system spends time with someone with infectious TB, he or she may become infected with TB bacteria and quickly develop TB disease.

## **Treatment**

People with TB disease can be treated and cured with appropriate medication. People who have latent TB infection but are not yet sick can take medicine so that they will not develop TB disease. A TB skin test is the only way to find out if a person has latent TB infection and is recommended for the following persons:

- ☐ Individuals who have spent time with a person with known or suspected TB disease
- ☐ HIV-infected persons
- ☐ Persons with immune compromising conditions and diabetes
- ☐ Persons who have symptoms of TB disease
- ☐ Persons from a country where TB disease is very common
- ☐ Persons who inject drugs
- ☐ Persons living in shelters, migrant camps, prisons and jails, and some nursing homes.

The medicine usually used for the treatment of latent TB infection is a drug called isoniazid or INH. INH kills the TB bacteria that are in the body and when taken correctly keeps individuals with latent TB infection from developing TB disease.

Most people must take INH for at least 6-9 months. Children and people with HIV infection may need to take INH for a longer time. Short-course regimens may be utilized for select high-risk clients including those co-infected with TB and HIV. Rifampin and

Pyrazinamide or Rifabutin and Pyrazinamide are two short-course treatment regimens. These regimens must be given via directly observed therapy and only after initial discussion with the TB Physician's Network (1-800-4TB-INFO) and the Bureau of Communicable Diseases (1-850-245-4350).

People are sometimes given treatment for latent TB infection even if their skin test reaction is not positive. This is often done with infants, children, and HIV-infected people who have recently spent time with someone with infectious TB disease. This is because they are at very high risk of developing serious TB disease soon after they become infected with TB bacteria. Active TB is treated with four drugs for six months. It is important that a person being treated take all medications as prescribed to avoid the possibility of multidrug resistant (MDR) disease. Also, a person with HIV disease who is cured of TB is at serious risk of developing another case of TB because of low resistance.

### **The Established Link between TB and HIV**

TB is the cause of death for one out of every three people with AIDS worldwide, making it the leading cause of death among people infected with HIV. Since HIV weakens the immune system, people with latent TB infection and HIV infection are at very high risk of developing TB disease. In fact, individuals who are infected with HIV and TB have a 100 times greater risk of developing active TB disease and becoming infectious compared to people not infected with HIV. CDC estimates that 10-15 percent of all TB cases and nearly 30 percent of cases among people ages 25 to 44 are occurring in HIV-infected individuals. In addition, people with HIV/AIDS are at greater risk of developing multi- drug resistant TB, a form of TB that does not respond to the typical regimen of medications and is often fatal (The Deadly Intersection Between TB and HIV, 1999).

All HIV-infected people should be tested periodically for TB to find out if they have latent TB infection. If they have latent TB infection, they need treatment as soon as possible to prevent them from developing TB disease. If they have TB disease, they must take medicine to cure the disease. TB disease can be prevented and cured, even in people with HIV infection.

### **Close Contacts Need to Be Notified**

People with TB disease are most likely to spread it to people they spend time with every day. This includes family members and people they work with.

## **References**

Florida Department of Health, Bureau of Communicable Diseases

Centers for Disease Control & Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV Prevention. Fact Sheet. The Deadly Intersection between TB and HIV, 1999.

Technical Assistance, TB3: Protocol for Tuberculosis (TB) Targeted Testing and Treatment of Latent TB Infection (LTBI). [http://www.doh.state.fl.us/disease\\_ctrl/tb/guidelines/TB3-TargetedTesting-LTBI.pdf](http://www.doh.state.fl.us/disease_ctrl/tb/guidelines/TB3-TargetedTesting-LTBI.pdf)

Division of TB Elimination: [www.cdc.gov/nchstp/tb](http://www.cdc.gov/nchstp/tb).

## RESOURCE: Self-Assessment for 501 Participants

Please describe your initial thoughts and feelings about the possible client types below and rate how comfortable you will be counseling these clients



*Initial Thoughts and  
Feelings*

Person with multiple sex partners						
Sex offender						
Person who has anal sex						
Sex worker						
Pregnant teen						
Unfaithful spouse or partner						
Gay man or lesbian						
Heterosexual						
Substance abuser						
Transgendered person						
Person with different religious/spiritual beliefs						
Alcohol abuser						
Illegal immigrant						
Atheist						
Unwed mother						
Child molester						
Person who has oral sex						
Injection drug user						

***Please use the back if additional space is needed***

1. How will you deal with persons who are gay, lesbian, bisexual, or transgendered? \_\_\_\_\_
2. How will you handle working with the homeless, substance abusers, sex workers, and incarcerated persons? \_\_\_\_\_
3. How comfortable are you talking to persons who do not share your beliefs? \_\_\_\_\_
4. How comfortable are you discussing explicit sexual information with strangers? \_\_\_\_\_
5. What would you do if you found yourself attracted to a client? \_\_\_\_\_
6. What would you do if a client started coming on to you (same and/or opposite sex)? \_\_\_\_\_
7. What thoughts or feelings about HIV risk behaviors do you have that could interfere with "client-centered" HIV prevention counseling? \_\_\_\_\_
8. How do you feel about working with persons who refuse to change their behavior? \_\_\_\_\_
9. How well will you be able to help clients reduce their risks in manageable ways (as opposed to abstinence based or no risk perspective)? \_\_\_\_\_
10. What do you expect will be the impact of your counseling on clients? \_\_\_\_\_

11. How are you going to cope with informing persons that they are HIV positive? \_\_\_\_\_

# **Module II**

## **HIV/AIDS 501**

### **FDOH HIV/AIDS Prevention Counseling, Testing and Linkage**





# **MODULE II**

## ***HIV/AIDS 501***

### ***Section A***

#### ***HIV Prevention Counseling***

## 501 COURSE OVERVIEW

The HIV Prevention Counseling, Testing, and Linkage (CTL) course (HIV/AIDS 501) is a course designed for persons who will be conducting HIV prevention CTL services. Completion is mandatory for persons providing these services in publicly funded CTL sites. These persons are also required to meet certain post-requisite requirements. In Florida, HIV testing is established and governed by section 381.004, Florida Statutes, Florida Administrative Code rule 64D-2.004, Internal Operating Procedures, and Model Protocols, all of which are in line with the HIV testing guidelines issued by the Centers for Disease Control and Prevention.

- A) Informed consent to perform a test for HIV in a non-health care setting need not be in writing, except in the situations listed below in subsection, if there is documentation in the medical record that the test has been explained and consent has been obtained. In health care and non-health care settings, informed consent to perform a test for HIV shall be in writing for the following:
  - (a) Prior to the first donation of blood, blood components, organs, skin, semen, or other human tissue or body part in accordance with Section 381.0041, F.S. The consent form must specify that the donor is consenting to repeated HIV testing of each donation for the subsequent year. The consent form must be signed annually prior to transfusion or other use;
  - (b) Prior to testing for HIV for insurance purposes, in accordance with Section 627.429, F.S.; or
  - (c) Prior to testing for HIV for contract purposes in a health maintenance organization, in accordance with Section 641.3007, F.S.
- B) All non-healthcare settings conducting HIV testing such as county health department HIV testing programs, community-based organizations, outreach settings, and mobile vans, etc. are required to provide HIV pre-and post-test counseling.
- C) Florida law requires a healthcare provider who attends a pregnant woman for conditions relating to her pregnancy to test for HIV and other STDs at the initial visit and counsel her on the availability of treatment if she tests positive. The physician shall inform the woman she will be tested for HIV and other STDs and of her right to refuse. If the pregnant woman objects to testing, a reasonable attempt must be made to obtain a written statement of objection, signed by the patient, which shall be placed in her medical record.

- D) The Florida Department of Health has developed the model protocols for HIV counseling and testing in healthcare and non-healthcare settings. All HIV registered test sites are required to follow the guidelines outlined in the model protocols for the purpose of HIV counseling and testing.

This course is divided into four sections:

- A. HIV Prevention Counseling
- B. Referrals and Linkages
- C. Quality Assurance/Quality Improvement
- D. Wrap Up

The 501 course objectives will enable participants to:

- ☐ Section A:
  - ☐ Identify the different types of communication.
  - ☐ Identify the ten basic communication skills in client-centered counseling.
  - ☐ Identify fundamental information on HIV prevention counseling.
  - ☐ Become more culturally competent.
  - ☐ Enhance their knowledge of special populations and circumstances and their unique impact on the provision of HIV prevention services.
  - ☐ Cultivate their skills and abilities in performing HIV risk assessments.
  - ☐ Develop their skills and abilities in conducting HIV pre- and post-test counseling.
- ☐ Section B:
  - ☐ Successfully execute referrals and linkages.
  - ☐ Identify the role of vital patient care services available.
  - ☐ Discuss the history and role of Partner Services (PS), formerly Partner Counseling and Referral Services (PCRS).
- ☐ Section C:
  - ☐ Recognize and discuss the purposes of Quality Assurance/Quality Improvement (QA/QI).
  - ☐ Discuss pre-requisites, requisites and post-requisites for HIV counselors.
  - ☐ Utilize appropriate QA/QI tools when assisting sites with technical assistance.
- ☐ Section D:
  - ☐ Identify a variety of symptoms and effects of burnout.
  - ☐ Identify ways to avoid burnout.
  - ☐ Provide a self-evaluation of counseling strengths and abilities.



# ***CHAPTER 1***

## ***Communication and Counseling Skills***

## COMMUNICATION AND COUNSELING SKILLS

The American Heritage Dictionary defines **communication** as the exchange of messages or information by speech, signals or writing. The verb **communicate** refers to the interchange of ideas and expressing oneself in a way that is clearly understood. In its noun form, **counsel** is the exchange of opinions and ideas and the offering of guidance. In its transitive verb form, to counsel is to advise and recommend.

When a person offers counseling to an individual, he/she is communicating. Communication takes place between the counselor and the client, moves in both directions, and can be performed poorly or well. Communicating with the client is what the counselor is trying to achieve in an HIV counseling session.

Several helpful **verbal** and **nonverbal** principles regarding communication are necessary to conduct a successful counseling session. Understanding these principles and the essential concepts of counseling assists the counselor with his/her successful interactions among individuals.

### Nonverbal Communication

There are six nonverbal principles of which the counselor should be aware before talking with a client. They are **eye contact, facial expressions, posture, body orientation, touch, and physical environment.**

1. **Eye Contact:** It is important to maintain **eye contact** when communicating with clients. Good eye contact does not mean staring a client down but rather looking into the client's eyes and glancing away. HIV counselors need to use good judgment with eye contact so as to avoid glaring at clients for this may indicate judgment. On the other hand, avoiding eye contact may imply the counselor has no real interest in the counseling session or the client. An extreme of either situation may make the client feel nervous. It is important to note that in some cultures, eye contact is limited or forbidden. The counselor should be culturally sensitive regarding foreign customs.
2. **Facial Expressions:** The counselor should be aware of the **facial expressions** he/she exhibits to what is said by the client. If the client says she had sex with five different men last night and the counselor looks astonished, it does not matter what is said from that point on. The client will likely assume from the surprised look that the counselor disapproves of that type of behavior and will be unlikely to cooperate from that point forward.

Reading the client's facial expressions when he/she is talking to the counselor may give a lot of insight into whether or not he/she understands the counselor or is even telling the truth. It may also tell whether or not he/she is comfortable with the counselor.

3. **Posture:** When communicating with a client, important nonverbal messages may be revealed through **posture**. If a counselor leans toward a client while listening to him/her talk, this action conveys a sense of interest in the conversation. (Be careful not to lean into the client's "comfort zone". Not everyone likes to feel someone in his/her face or space. It is best to sit up straight and lean slightly forward. You will sense the client's comfort boundary when he/she starts pulling back from you.)

If a client behaves aggressively in a counseling session, the counselor may help to ease the situation by relaxing in his/her own chair and sitting slightly back. This display of calmness may have a calming effect on the client.

Along with posture is body movement. A client's nervous fidgeting, constant hair touching or other behaviors should elicit a response from the counselor to address what the client is feeling.

4. **Body Orientation: Good body orientation** can project important nonverbal messages. The counselor is most effective when facing the client and putting him/herself in a position to listen to the client and concentrate on what he/she is saying. Too much distance may cause a breakdown in the communication process, while sitting too close to the client may prove to be uncomfortable. Respect personal space.

Also, be careful about crossing your arms. This may imply a closed attitude and may convey, from the client's point of view, that the counselor feels a sense of superiority.

5. **Touch:** When appropriate, this can communicate to clients that you care. A **touch** on a shoulder, a hold of a hand or even a hug can mean more than words. Realize that not everyone can handle physical touch. However, you can "touch" someone in many ways, including listening without a preconceived agenda.
6. **Physical Environment: The physical environment** plays an important role in the nonverbal communication process. The office where the counseling session takes place should be private with a closed door. This provides a sense of confidentiality to the client. They may be unwilling to talk openly about risks if there is any chance someone else may be able to hear the conversation.

The chairs in the room should be on the same side of the desk and facing each other. (This configuration encourages open communication.) The counselor should be closer to the door than the client. This allows the counselor to be able to get to the door easily if the client threatens the counselor's safety. In addition, the client is less likely to get up to leave, especially when being given HIV negative results in a post-test counseling session. The counseling area should have a clean, uncluttered and professional look, free of physical barriers, which may cause unneeded distractions for the client.

Be sure posters, pictures and items in the room convey an appropriate, soothing environment. Macabre items (such as skulls and graveyard posters) would be inappropriate in a room where post-test positive counseling is to be held. There should also be no telephone calls or beepers going off during the session.

Remember: Most of our communication is nonverbal. It is often how we say (or don't say) something that matters more than the words.

## Verbal Communication

Verbal communication includes both spoken and unspoken messages using words and symbols. There are nine principles of verbal communication. They are **brevity, organization, primacy, comprehension, repetition, tone of voice, volume, speed, and inflection.**

1. **Brevity** refers to the length of the communication. It is always best to keep a message short and simple. People often forget lengthy messages loaded with information. For example, television commercials are usually less than thirty seconds in length, yet they convey what the advertisers think is one important message about a product or service. The counselor should keep the message concise.
2. **Organization:** The message to be conveyed to the client should be **organized** in a logical and sequential manner. This will prevent rambling and jumping from point to point.
3. **Primacy** is the order in which information is presented. Individuals are more likely to remember the first item he/she hears in a message. In a newspaper article, the main point is usually in the first paragraph. This is because people rarely read the entire article. Similarly, the client is more attentive at the beginning of the counseling session, so important points should be discussed early.

4. **Comprehension:** For a message to be effective, the **comprehension** level must be adjusted to that of the client. If technical terms are used and the client does not understand, the message will be lost. If the message is too simple, the client may become bored or insulted. If, for instance, a client does not understand what antibodies are, the counselor may explain them as the body's soldiers that fight off foreign invaders. If medical language is used during the counseling session, the client may understand little.

A good way to determine the client's comprehension level is to ask for his/her understanding of HIV and then listen attentively to the words he/she uses in answering. Your response can then be given to the client at his/her comprehension level.

Use acronyms sparingly. When they are used (e.g., HIV, AIDS) be sure they are explained.

5. **Repetition:** There are certain points in a communication that should be repeated in order to emphasize their importance. **Repetition** is used in television and radio commercials because people are more likely to remember a point if they hear it several times.
6. **Tone of Voice:** In a counseling session, a pleasant and professional **tone of voice** should be maintained. It is easy to become judgmental and condescending, and an effort should be made to avoid that.
7. **Volume:** It is best to speak in a normal range of **volume**. If the conversation becomes too loud, the client may become concerned about the confidentiality of the information being exchanged. If the counselor speaks too quietly, the client may not hear the message. Speaking too quietly may also cause the client to feel that the subject being discussed is seen as unsavory by the counselor.
8. **Speed:** The **speed** at which the counselor speaks can be crucial to whether the message is conveyed. If the counselor speaks too quickly, the client may get lost and not remember any of the messages. It is best to speak slowly and clearly. Give the client time to absorb some of the message. A strategically placed pause can emphasize a point in the same way a period does at the end of a sentence. (On the other hand, don't speak too slowly. This could convey the message that the client is too ignorant to understand what is being said).
9. **Voice inflection** refers to variations in the pitch of the voice. It is best not to speak in a monotone (a dry, single-tone, single-volume voice), but to change speech patterns. Raising or lowering the voice may emphasize a point. Injecting emotion into the speech pattern can do the same.

## **Basic Counseling Skills**

There are ten basic counseling skills that are used in HIV counseling. They are: **open questioning/open-ended questions, attending, paraphrasing, reflective feelings, reframing, confrontation, self-disclosure, giving information simply, using humor and summarizing.**

1. Open Questioning/Open-ended Questions

**Open questioning** is asking questions that require more than a single word answer to encourage conversation. When counseling a client, it is best to ask questions that begin with **who, what, where, when, why, and how.**

Questions that begin this way subtly demand an answer that goes beyond **yes** or **no**. There may be questions where only a yes or no answer is needed. However, open questions invite the client to answer in a more straightforward manner, and it is more difficult for him/her to answer untruthfully. For example, suppose it is known from a prior medical record that a client has used injection drugs. If the question, "You're one of those IV drug users, aren't you?" is asked, there would be a higher likelihood of getting an untruthful answer. If the question was asked, "When was the last time you injected drugs?", the counselor is less likely to sound judgmental. And, since the patient has to ponder a thoughtful reply, he/she is less likely to lie. Here are other examples of how to use open questioning:

"What brings you to the clinic today?"

**- instead of -**

"Are you here for an HIV test?"

"When was the last time you had sex with a man?" (If the client is male.)

**- instead of -**

"You're not gay, are you?"

"How many sex partners have you had in the past six months?"

**- instead of -**

"You're not promiscuous, right?"

Here are some examples of closed questioning:

“Do you have many sex partners?”

“Have you had sex recently?”

“Did you do anything to put yourself at risk?”

(Many clients will assume that the answer the counselor wants to hear is “**no**”.)

**Closed questions** do not allow the client to open up and speak freely. Open questions stimulate discussion and create a more relaxed atmosphere for discussion and decision-making.

**Polite imperatives** may be used in place of open questions. These are statements that demand a reply although they are not “asked” in the form of a question. Examples of a **polite imperative** would be:

“Please tell me what your concerns are.”

“Let me know what prompted you to come into the clinic today.”

“Please explain what you mean by ‘a few partners.’”

It is possible to ask an open question in a negative way. Often the “**why**” questions make people defensive because they are usually asked “**why**” about a negative behavior. For instance, a parent might ask his/her child, “Why would you do something like that?” Although the question demands something more than a yes or no answer, it makes it difficult to reply. A counselor may ask a client, “What were you thinking when you did those things that put you at risk for HIV?” This is an example of a negative open question that should be avoided.

A way to turn a negative open question into a positive one might be to ask the client, “**Tell me what you have been able to do to keep from becoming infected.**”

## 2. Attending

**Attending** means that the counselor should clear his/her mind of distractions before the counseling session and give complete attention to the client. It is best to avoid “canned” or preconceived speeches and messages. The counselor should relax and be straightforward with questions and comments. The counselor should be open and flexible to the needs of the client.

Physical barriers can interfere with **attending** to the client’s needs. Maintaining eye contact, being mindful of body language (both the client’s and the counselor’s), and watching for other nonverbal cues are important. If the counselor gives the

impression he/she is not interested in the client, and this is obvious to the client, the session will not be successful. To affect behavior change in the client, the counselor must show he/she has an interest in the client and the counseling session.

Hearing is the physical act of sound waves reaching the outer ear. Listening, however, is **attending** to the message that is being delivered.

When you are delivering an educational message, encourage the person/client to talk. Listen carefully to what is being said. By listening you will have a better understanding of what concerns your participants.

Good listening includes:

1. Concentrating on what the person is saying
2. Restating his/her words or general point; Identifying his/her feelings
3. Not interrupting
4. Not giving advice; Remember we are there to deliver the facts! Your advice may make you feel better, but it keeps your clients from thinking through his/her issues and accepting responsibility.

Using questions effectively:

1. Use the above mentioned open-ended questions. Never use questions that can be answered with a simple yes or no when you need detailed information.
2. Appropriate and inappropriate questions; If someone asks you a question that seems inappropriate, there are many ways to handle it. If it's a question that you do not know the answer to, you may wish to provide resources where he/she can possibly get that information, such as a hotline telephone number. If people ask personal questions, remind them that you are there to focus on the client, not yourself.

Responding:

1. Respond with empathy, respect, and genuine warmth.
2. Accurate empathy: never say that you know how he/she feels, but you can let him/her know how you would respond in that situation, etc.
3. Respect the participants enough to have faith that the person can cope with and solve his/her problems.
4. Genuine warmth, caring and concern for another person are always helpful.

### Problem Solving:

1. Allow the group and/or individuals to come up with the possible plans of action.
2. Act as a clearinghouse for resources and information to help address and answer problems.

### 3. Paraphrasing

Occasionally, the client will make a statement and the counselor will need to restate or **paraphrase** this statement to be sure he/she understands what the client is really saying. The counselor must be an active listener to accurately paraphrase what the client is saying. If the client says he/she is "almost monogamous," the counselor might paraphrase that statement by replying, "What I hear you saying is that you have had more than one sex partner. How many people have you had sex with in the past six months?"

When paraphrasing, a polite imperative may be useful. If the client says, "It's been quite a while since I've had sex," the counselor's reply might be, "Please tell me how long it's been."

An effective paraphrase can elicit and facilitate more communication from a client than a well-asked open question. At certain times during the counseling session, paraphrasing can show the client that the counselor is interested and is paying attention. It checks the counselor's understanding of what the client is saying. Paraphrasing focuses the client on what he/she is saying. It can keep the session on track and keep the counselor from giving the client unsolicited advice.

### 4. Reflective Feelings

When the counselor paraphrases what the client has said, he/she usually focuses on content. With **reflective feelings**, the counselor is reflecting back to the client what is said and the focus is on feelings. The more a counselor can learn about what is affecting the client, the better the chances of working out solutions to the problems the client is having.

It is okay for the counselor to empathize with what the client is feeling, but the empathy must be accurate. If the client says he/she has had sex with an HIV- infected individual and he/she must be infected, it is not okay for the counselor to say, "I know exactly how you feel." It would still not be okay even if the counselor really had had that same experience. A more appropriate response might be, "I

have a friend who felt a similar way” or, “If I were you, I’d probably have similar feelings.”

The counselor should identify what the client is feeling, along with the level of intensity of the feeling. They need to determine if the feelings the client is experiencing are associated with the content of the counseling session or if they are something unrelated. The counselor should then formulate a response.

A reflected feeling might be:

- “This can be a difficult situation for anyone to deal with.”
- “It is okay to be scared.”
- “You seem confused (any feeling word may be inserted here). Tell me what’s going on in your mind.”

When reflecting feelings, the counselor may be incorrect about the reflected feeling. For instance, the counselor might say, “Gosh, that must make you really scared,” when, in fact, the client is really angry. Some counselors may be uncomfortable about presuming to know how someone else is feeling. They must remember his/her job as the counselor: he/she is in this session to be helpful to the client. The counselor must help the client to make some important decisions about the client’s behavior.

Some **INAPPROPRIATE** or **INEFFECTIVE** ways of reflecting feelings are:

- to say to the client, “I understand completely.”
- using a feeling word that is very different in intensity from how the client really feels
- using a cold tone
- using psychological babble or clinical jargon
- sounding judgmental
- arguing with the client about his/her feelings.

Some **APPROPRIATE** ways of reflecting feelings are:

- to demonstrate understanding of the client’s feelings and situation
- to develop a rapport with the client
- to confirm the client’s feelings are okay
- to demonstrate the client’s feelings are an important part of the counseling session.

## 5. Reframing

**Reframing** is paraphrasing (or reflecting feelings) on the part of the counselor who has captured the client's perceptions or feelings, expresses a level of understanding or agreement with client, and then reframes those perceptions or feelings by offering a more positive view. For example, a client says, "You can't feel anything when you wear condoms!" A reframe might be, "You're right, condoms do reduce sensation and lots of guys find that lets them stay hard longer."

Signs of ineffective reframing:

- ☐ "(Paraphrase/reflecting feeling) BUT (reframe)"; Use of the word "but" may appear to minimize the client's statement.
- ☐ Offering the reframe as the only or "best" view of the issue
- ☐ "Boxing" (arguing over what was said or the intended meanings) with client.

## 6. Confrontation

During the course of the counseling session, the client may make a statement that is contradictory to a previous statement or there may be a noticeable difference between the client's verbal and nonverbal message. The client may picture him/herself one way but one or more statements show him/her in a completely different light. It may be necessary for the counselor to confront the client about a contradiction. This **confrontation** should be done in a professional and nonjudgmental way.

Suppose the client indicates he/she is aware of how HIV is spread, yet he/she has several sexual partners and rarely uses condoms. They are not concerned about infection because he/she is not gay and does not shoot drugs. Perhaps another client claims to have abstained from shooting drugs for a "good long while". However, later in the conversation he/she describes a drug experience that took place just last week.

These inconsistencies need to be confronted by the counselor and handled in a way that is comfortable for the client and the counselor. The counselor should ask directly and openly about the inconsistency. If the client refuses to explain the contradiction or shuts down, the counselor may choose to let it go - to continue on with a different topic. The counselor should not be drawn into an argument with the client or continue pressuring the client until he/she gets the answer he/she is looking for. The counselor can only point out contradictions. It is up to the client to either accept it or not. The counselor must be willing to let go, which means giving the responsibility for actions to the client where it belongs. Let the client

know you are ready to readdress the issue whenever he/she wants to. You will be seen as helpful, not pushy, and the client will be more likely to return.

## 7. Self-Disclosure

A counselor may choose to disclose some personal event or situation to the client that helps with the client's situation. **Self-disclosure** will shift the focus away from the client momentarily, and there may be appropriate times during the session to do that. Even though the counselor may have never "walked in the shoes" of the client, there may be some self-disclosure item that can be shared to show the client that the counselor understands how he/she feels. Occasionally, the client will attempt to get the counselor to self-disclose. When this happens, the counselor might say, "How will knowing this about me assist me in helping you?"

Again, accurately empathizing is fine. It is not fine to tell a client he/she is understood completely when the counselor has never had a similar experience.

A word of caution: self-disclosure could backfire and therefore should be used sparingly. If not, the self-disclosure can be used by the client to avoid talking about his own situation. Also, what the client says to the counselor is confidential, but what the counselor says to the client is not.

## 8. Giving Information Simply

Rather than covering a rehearsed list of "HIV-101" items in the counseling session, the counselor should find out the client's current knowledge level regarding HIV/AIDS. The counselor should then **give information simply**. According to many surveys that have been done nationwide, most Americans know how HIV is transmitted and how it can be prevented. The problem is not getting messages to the client. The problem is the client's ability and willingness to use that knowledge to change his/her behavior.

During the counseling session the client should be asked, "What do you know about how HIV is transmitted?" or, "Tell me what you already know about HIV." These questions give the counselor the opportunity to clarify any misinformation the client has and confirm the correct information. This gives the counselor an opportunity to gauge the client's comprehension level and should be done in a simple and straightforward manner.

Here are some points to remember when giving information to the client:

- Identify what questions or concerns the client has.
- Formulate simple, non-technical responses.
- Clarify any misinformation.
- Confirm and congratulate the client on his/her awareness of good information.
- Information should be concise (clear and to the point).
- When the counselor cannot answer the client's question, he/she should not make up an answer but make a referral to a separate resource. Counselors will not know everything about medical science or how HIV works.

## 9. Using Humor

At times during a counseling session, it may be appropriate to "lighten" the conversation by using **humor**. Using humor may be more useful during prevention counseling (before the client decides whether or not to be tested) than during a post-test counseling session.

When the counselor uses humor, he/she should do so in a professional manner (but never overuse it). An inappropriate use of humor would be if the client confided that his/her partner is HIV infected and the counselor said something like, "Well, it looks like he's gonna die, but I believe we can save you." Occasional light inflections are fine, but the counselor must size up each individual client and make a decision as to whether or not humor will be appropriate in that particular situation.

Humor is rarely useful if it is pre-packaged or canned. It works best when it is spontaneous. Some counselors will be better at the appropriate use of humor than others. If a client says something funny, this may be an opportunity for the counselor to use humor to stress a point or build rapport.

It is okay to interject humor during a counseling session, but it must be done appropriately and with sensitivity to the client. Every client is different, and not every client will appreciate a humorous moment during the counseling session.

Four things should be remembered when humor is employed during the counseling and testing session:

- ☐ Size up the individual client to determine whether or not humor should be employed.
- ☐ Use humor appropriately and sparingly.

- ☐ Try to be spontaneous and not appear to be repeating a memorized script.
- ☐ Do not repeat humor just because one client accepted it. The next person may not receive it the same way and it ends up being your canned "act".

## 10. Summarizing

The counselor should formulate and deliver a statement that briefly describes what commitments the client has made regarding risk reduction and elimination, as well as linkages. Closed questions (yes or no) may be used to expedite the **summarization** process. The closing remarks create a confirming and supportive reminder to the client of the agreements made between him/her and the counselor.

The counselor may ask the client what questions he/she has about anything that has been discussed. Much may have been discussed about behavior change during the counseling session. Many clients are willing to listen to suggestions and make behavior changes, especially when there is "something in it for them." For instance, if he/she is having sex with strangers without using barrier protection (condoms), he/she may not have understood the danger in that behavior until talking with the counselor. Some clients will listen to reason and logic, and respond reasonably. For clients who truly will not change no matter how the counseling session progressed, the counselor may find it necessary to just "let go." Many counselors find this difficult to do. For every client who refuses to change his/her behavior to reduce or eliminate HIV risk, maybe ten or fifty others are willing.

The summarization should include any words of support to the client about proposed behavior changes he/she plans to make. The client should be doing the majority of talking in the session, with the counselor providing the information the client says or indicates he/she needs. To keep a conversation flowing (and to show the client you are listening), you should form your next question based upon what the client has just told you.

## The Nth Degree

Client-centered counseling is enhanced when the counselor goes to the nth degree in asking questions. Going to the nth degree is identifying the greatest need or most important problem to be addressed by a client. By asking the client nth degree questions, the client is allowed to define their priorities, agendas and needs and the counselor doesn't make the assumption that they know what is most important to the client.

Suppose a client has expressed several reasons why he/she doesn't want to get tested. A counselor should acknowledge the client's feelings and ask "What is it about testing that concerns you the most?" This allows the counselor to tailor their discussion to what is most important to the client and thus save counseling time by not addressing a lot of side

issues. It also allows the client to pinpoint what is the worst part of the experience for them, which differs among people.

Another example would be a client who has expressed many reasons why a condom was not used. The counselor should then ask, "What is the main reason you don't want to use a condom?" This allows the client to take ownership of their problem and gives the counselor an opportunity to get to the basic problem.

Using nth degree questioning is especially helpful in opening a counseling session because you will quickly find out the client's agenda. For example, you could ask "What is concerning you the most today that you would like to talk about with me?" Or, "If we could deal with only one thing today, what one issue would be most important to you?"

Other examples of questions that take us to the nth degree are:

"What's the worst thing that could happen?"

"What's the scariest part of this?"

"What is the main thing that is keeping you from talking to your partner about using condoms?"

Some counselors claim they are pressured by hectic clinic schedules which sometimes results in not having enough time to address all the issues a client may have. If this is really the case, going to the nth degree in questioning will ensure that the time allotted is used wisely and addresses what the client identifies as being most important to them.

## **SUMMARY - COMMUNICATION AND COUNSELING SKILLS**

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### **Nonverbal Communication**

1. Eye Contact - Not too much and not too little
2. Facial Expressions - Be aware of your and your client's facial expressions during session.
3. Posture - Do not slouch or appear uninterested in client.
4. Body Orientation - Face the client and keep proper distance.
5. Physical Environment - Door should be closed for privacy, check placement of desk & chairs.

### **Verbal Communication**

1. Brevity - Make points concisely.
2. Organization - Be logical & sequential with message to client.
3. Primacy - Place important point(s) at beginning of communication.
4. Comprehension - Do not talk above client's head.
5. Repetition - Repeat very important points.
6. Tone of Voice - A pleasant tone should be maintained for the comfort of client and counselor.
7. Volume - Do not talk loudly or softly.
8. Speed - Do not speak too fast for the client to understand or too slowly.
9. Inflection - Change speech patterns appropriately so as to hold the interest of the client.

### **Basic Counseling Skills**

1. Open Questioning - Who, what, where, when, why, and how
2. Attending - Clear mind of things that may distract you during counseling session.
3. Paraphrasing - Rephrase or repeat what client has said in different words for understanding.
4. Reflective Feelings - Identify client's feelings and the level of intensity. Ask about him/her.
5. Reframing - Paraphrasing or reflecting feelings on the part of the counselor who has captured the client's perceptions or feelings
6. Confrontation - Ask the client about contradictions and inconsistencies.
7. Self-Disclosure - Use a personal event to stress a point.
8. Giving Information Simply – No extended details of HIV facts and statistics; Keep it simple.
9. Using Humor - Okay to use humor at appropriate times
10. Summarizing – At end of session review what was said and any agreements.

# ***CHAPTER 2***

## ***Fundamentals of HIV Prevention Counseling***

# FUNDAMENTALS OF HIV PREVENTION COUNSELING

## Introduction to HIV Prevention Counseling

Since 1993, the Centers for Disease Control and Prevention (CDC) have recommended one interactive counseling approach, client-centered HIV prevention counseling. Client-centered HIV prevention counseling is a process that is aimed at personal risk reduction by helping clients identify and commit to a specific behavior change step. This type of counseling has been shown to be effective in reducing HIV acquisition among high-risk persons with negative or unknown HIV status and transmission from HIV-infected persons. In some HIV test sites, counselors deliver a face-to-face informational message in response to the checklist of risk behaviors on the DH 1628 Laboratory Request Form or other risk assessment forms. This type of “counseling” is considered to be “information dissemination” and “data collection”, not client-centered HIV prevention counseling.

HIV prevention counseling should be used in HIV risk assessments and in pre-test and post-test counseling sessions. The primary goal of HIV prevention counseling is risk reduction. This is brought about through an in-depth personalized risk assessment and negotiation of an individualized risk-reduction plan that is concrete, acceptable, and achievable. Other elements of HIV prevention counseling include an assessment of the client’s knowledge of HIV/AIDS and clarification of misconceptions about transmission, acknowledgement and support for positive steps that the client has already made, and skills-building exercises (as appropriate).

Counseling sessions should be tailored to address the personal risk of the client rather than to provide a predetermined set of information unrelated to the client’s situation. The session should not be sidetracked by the client’s additional issues unrelated to HIV (linkages may be made as needed). Counseling techniques such as use of open-ended questions and role play scenarios, attentive listening, and maintaining a nonjudgmental and supportive approach can encourage the client to remain focused on personal HIV risk reduction.

Counseling should not be a barrier to HIV testing. Any client requesting an HIV test should be given one. Likewise, focusing on increased HIV testing should not be a barrier for the provision of effective HIV counseling services for at-risk clients.

## **Goal of HIV Prevention Counseling**

The goal of HIV prevention counseling is to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV.

The focus of HIV prevention counseling is to more effectively support clients in:

- ☐ identifying their HIV risk behavior and circumstances
- ☐ identifying specific risk reduction goals
- ☐ developing a realistic personalized action plan to achieve these goals.

Assisting clients in identifying personal risk behaviors and circumstances and developing action plans, with or without testing, is a key component of effective HIV prevention counseling. However, counselors need to be aware of factors that influence HIV risk behavior change. See the chart in the “Personalizing Behavior Change” section below.

## **Six Steps of HIV Prevention Counseling**

Along with necessary information to meet the legal and procedural requirements of the state and the Florida Department of Health, six basic steps are to be included in the risk assessment and in pre-test and post-test counseling sessions. Those steps are:

- 1. Introduce and orient the client to the session.**
- 2. Identify the client’s personal risk behavior and circumstances.**
- 3. Identify safer goal behaviors.**
- 4. Develop client action plan.**
- 5. Make linkages and referrals.**
- 6. Summarize and provide support.**

## **Personalizing Behavior Change**

The Centers for Disease Control and Prevention established client-centered HIV counseling standards in 1993. During a counseling session, the HIV counselor should use these standards to help the client personalize his/her behaviors and work toward a positive change. Three CDC standards for HIV prevention counseling are:

1. Establish and/or improve the client’s self-perception of risk.
2. Identify and support behavior changes the client has already attempted.
3. Negotiate a realistic and incremental plan for reducing or eliminating risk.

There are different models used for changing behavior. Two of these models will be discussed in this section.

First, the “**Counseling Model of Behavior Change**,” developed by Joan M. Garrity at CDC, can be used to illustrate how behavior change should be personalized. This model draws its content from several theories on behavior change.

Behavior change cannot take place until the individual whose behavior needs changing takes ownership of his/her undesirable behavior, and change becomes significant to him/her. Garrity’s model includes the following steps:

- ☐ Knowledge Awareness
- ☐ Self-Efficacy
- ☐ Significance to Self (Personalizing the Risk)
- ☐ Cost/Benefit Analysis
- ☐ Capacity-Building
- ☐ Provisional Try
- ☐ Behavior Change.

### **1. Knowledge Awareness**

Because of the vast amount of information that has appeared in the media in the last several years, most clients have a basic understanding of HIV and how it is transmitted. In the context of an HIV counseling session, the counselor should ask the client what he/she has heard about HIV and AIDS. What does the client know about avoiding infection? What has the client done to avoid HIV infection? The counselor should make an assessment of the client’s knowledge and risk of infection. As concisely as possible, the counselor should provide the information necessary to fill any gaps the client has in his/her knowledge of HIV. Knowledge awareness is necessary for movement toward behavior change.

- ☐ Assess what the client knows about HIV/AIDS.
- ☐ What does he/she know about how to avoid infection?
- ☐ Fill in the gaps and correct misinformation, if any.

An example of knowledge awareness and behavior change can be applied to cigarette smoking. The number of people who smoked cigarettes increased dramatically from the 1920s until the 1960s because there was very little published about the dangers associated with smoking. When the Surgeon General’s report on the negative consequences of cigarette smoking became available in the 1960s, there was knowledge awareness which led many smokers on a path to behavior change. Despite the knowledge of possible consequences, many people continue with risky behaviors.

## 2. Self-Efficacy

Self-efficacy is closely related to self-confidence. It is a positive self-regard and a sense of personal value and self-esteem. It demands the individual take responsibility for his/her own actions, good or bad. It involves self-control. The individual must make up their own mind to change their behavior. It is their decision to take a certain action.

The client must understand that they could become infected with HIV if they take the type of risks that lead to infection. Only they are capable of avoiding the risks associated with infection. No one else can prevent them from becoming infected. They can only prevent infection themselves.

- ☐ The individual takes responsibility for his/her actions, good and/or bad.
- ☐ The individual must make up their mind to change their behavior.
- ☐ It is his/her decision to take action.
- ☐ The client must understand that he/she can become infected if he/she does things that put him/her at risk.
- ☐ No one but the client can prevent his/her becoming infected. (It might be useful for the counselor to ask him/herself -- and ultimately his/her clients: "Who makes the decisions in terms of sexual activity or other risky behaviors?" "What type of decision process is involved?")

## 3. Significance to Self (Personalizing the Risk)

In order to influence people to change their behavior, they need to know why this change is significant to them. Many people are not aware that they are at risk of getting infected with HIV, even though they have behaviors which may lead to infection.

A person who has multiple sex partners may not be aware that they are at risk of infection because of the common view that primarily homosexual men and injecting drug users get HIV. Some who are at risk may even deny that risk. They may not believe information they hear regarding their risk or may ignore it.

- ☐ Clients need to know why a behavior change is significant to them.
- ☐ Some people are not aware they are at risk from what they are doing.
- ☐ Some people may be denying their risk.

An HIV counselor can help a client to understand their risk by asking questions like: "What if this were to happen to you?" or, "How would you feel if you became infected?" or, "How would you feel if your partner was infected?"

#### 4. Cost/Benefit Analysis

A behavior change may have a significant cost for the client, but the benefit may be even greater. The client may not immediately recognize the benefit of positive behavior change. For instance, because the client's steady sex partner has multiple contacts (even though the client does not); it might be to the client's benefit to leave the relationship. If the relationship is one of many years, it would be at a major cost to the client to dissolve this relationship, especially if he/she is dependent on the partner for subsistence. If the alternative is to get the client to use a condom every time he/she has sex with that partner, that may be a difficult behavior change if the client is willing but the partner is not.

The counselor may be able to identify what the client is now doing to work toward a behavior that reduces or eliminates his/her risk of HIV infection. The client may already have knowledge awareness and has already realized the self-significance. They may have weighed several options for behavior change.

As an analogy, assume someone is trying to stop smoking. Usually you cannot just tell him/her "Just don't smoke anymore". This may work for some people, but others need options. They may need to taper off over a period of time before giving up smoking completely.

The situation is similar in reducing the risk of HIV transmission. If injecting drug users are not willing to give up the drug use, they may be able to see the benefits of not sharing needles, and give up that behavior. Sexually active individuals may not be willing to become celibate, but they may be willing to limit the number of sex partners or try using condoms. Giving options for behavior change can lead to desirable results.

Positive ways the counselor can help the clients analyze the benefits and costs of changing their behavior is to ask questions like: "What are you doing now that you would like to change?" or, "What is it you are doing that's working?" or, "What is the most difficult thing about changing?"

- ☐ A behavior change may have a cost to the client, but the benefit may be greater.
- ☐ Clients may not immediately recognize the benefit of a positive behavior change.
- ☐ Help the client come up with a plan to change risk behavior and see the benefits.

- ☐ Ask the client “What are you doing now that you would like to change?”, “What are you doing that is working?”, and/or “What is most difficult about changing \_\_\_\_\_?”

Counselors need to be careful not to lead the client into an HIV risk-reduction behavior change which may put the client at risk for other harm. For instance, if a client is in a potentially violent relationship, demanding condom use each time there is sexual contact could increase his/her risk of injury.

## **5. Capacity Building**

The client needs to know he/she has the capacity to change his/her behavior. They need someone else to be on their side and provide encouragement. The counselor is the first person who can provide support. The counselor can congratulate the client for any steps taken to change his/her behavior in a positive way. The counselor also needs to provide tools to help the client along this behavior-change pathway.

If a client has never used a condom, he/she will need skills to even try using them. The counselor can demonstrate the use of a condom and give condoms to the client. However, that will not be sufficient to get the client to use one. The counselor should ask the client why some people do not use condoms even when they know, if used properly, condoms will help prevent HIV, pregnancy, and sexually transmitted diseases. When the client has an objection, the counselor can address that particular issue with the client.

- ☐ Let the client know he/she has the capacity to change his/her behavior.
- ☐ Be on his/her side. Provide encouragement.
- ☐ Congratulate the client on any behavior change, regardless of the size.
- ☐ Help the client with skill building: how to use a condom, not to recap needles, etc.
- ☐ Link to support/services.

## **6. Provisional Try**

A client may have to try something several times before being able to make a permanent behavior change. Many overweight individuals are willing to try some particular behavior to lose weight. This may involve reducing calorie intake and/or vigorous exercise. They probably will not maintain the good behavior without occasional or constant encouragement.

A sexually active person may be willing to try condoms. Their excuse for not buying and using them previously may be cost or embarrassment. They may not continue to

use them consistently without some type of encouragement or enticement. The client should be given condoms to take home from the counseling session, and this may be all he/she needs to use them consistently.

Rarely do behavior changes become permanent after one provisional try. After learning the benefits of stopping smoking, how many people can simply stop and never pick up another cigarette? After realizing the benefits of daily exercise, how many people continue a regular regimen after their initial try?

It is useful to have encouragement as the provisional tries are made, but the client may not have a friend or family member with whom he/she can discuss his/her behavior change. The counselor may need to help the client explore sources of continued support for his/her behavior change.

The counselor may ask questions like: "What will help you to change your behavior?" or "When will you try this new behavior?" or "What will be the most difficult part of this change for you?"

There will always be obstacles and setbacks. As long as the client moves two steps forward at a time and only one step back, there is progress. Someone once said that there are no obstacles, just learning experiences.

- ☐ It may take several or many times before a permanent behavior change can occur.
- ☐ Offer encouragement for any provisional tries made or that he/she has agreed to make.
- ☐ Give him/her linkages and referrals for additional support.
- ☐ Let him/her contact you as well for additional support.

It is unlikely that the counselor will have more than one or two contacts with the client. This method stresses the importance of repetition of key points and summary with the client as covered in the counseling skills section of the manual. It also demonstrates the importance of appropriate linkages to where needed help and encouragement are likely to be available. (Such help may be particularly needed during the "provisional try" experience).

## **7. The Behavior Change**

Within this model from "knowledge awareness" to positive "behavior change" which reduces or eliminates HIV risk, the client may move back and forth from one part to another. They may need to re-evaluate their knowledge awareness and its

significance in their life, reanalyze the costs and benefits, and provisionally try the changed behavior again.

The counselor becomes an important figure, because he/she is usually the first to suggest the client make a positive change in his/her behavior. The counselor may need to be available to the client on more than one occasion. In addition, the client will need other community resources on which he/she can call in order to personalize his/her risk of HIV infection and his/her behavior change.

### **Development of Personalized Prevention Plans: Working With Clients to Develop a Realistic Plan for Reducing Their HIV Risk(s)**

Help the client establish a personal plan to reduce their risk of HIV. The plan should be realistic, yet challenging and should address the specific behaviors identified by the client during the risk assessment phase of the counseling session and should incorporate the client's previous attempts, perceived personal barriers, and perceived personal benefits of reducing HIV risk. Solicit questions and reinforce the client's initiative in agreeing to try to negotiate a risk-reduction plan.

Suggested open-ended questions to use when assisting clients to develop a personal risk-reduction plan:

- ☐ What one thing can you do to reduce your risk right now?
- ☐ What can you do that would work for you?
- ☐ What could be done differently?
- ☐ How would your sex practices (drug related practices) have to change for you to stay safe?
- ☐ Now that you have identified some steps you can take, how can you go about making them happen?
- ☐ How realistic is this plan for you?
- ☐ How will things be better for you if you...?
- ☐ How would your drug practices have to change to stay safe?

Suggested statements supporting and reinforcing the client:

- ☐ You have done something good for yourself in putting this plan into place.
- ☐ You have taken very positive steps today to help meet some important goals.

## Linkage and Support

Identify client peer and community support for HIV risk reduction, as well as provide linkage and referral to professional services directed at addressing specific issues the client may have identified.

### Suggested Questions:

- ☐ We have talked about a lot of issues today. Which of the things we have talked about would you like more help with?
- ☐ Would you like to talk with an individual counselor about...? Would you be interested in a support group?
- ☐ Is there a particular kind of support or service that you would be willing to consider?

## Factors that Affect Behavior Change

This model looks at different factors that affect behavior change and incorporates them into a personalized prevention plan. Please refer to the table for definitions and examples.

### Factors that Affect Behavior and Examples

FACTOR	DEFINITION	EXAMPLES
Knowledge	Basic factual information of how one gets a disease and how to protect oneself from it.	<input type="checkbox"/> Knows condoms reduce risk of HIV/STD <input type="checkbox"/> Knows where to get condoms <input type="checkbox"/> Knows steps to use condoms
Perceived Risk	Feeling vulnerable to a health problem	<input type="checkbox"/> Believes he/she may get an STD or HIV, or if a woman, pregnant, if condoms are not used
Perceived Consequences	What one believes will happen, either positive or negative, as a result of performing a new behavior	<input type="checkbox"/> Thinks partner will be angry if asked to use condoms

FACTOR	DEFINITION	EXAMPLES
Access	The existence, affordability and accessibility of services and products needed to support a particular behavior.	<input type="checkbox"/> Can buy or get free condoms <input type="checkbox"/> Has condoms on hand <input type="checkbox"/> Carries condoms
Skills	The abilities necessary to perform a particular behavior	<input type="checkbox"/> Can put on and remove a condom correctly <input type="checkbox"/> Can negotiate/talk to partner
Self-Efficacy	Belief or confidence that one can do a particular behavior	<input type="checkbox"/> Believes that he/she can negotiate with partner to use a condom
Actual Consequences	Actual experiences, both positive and negative, in doing a particular behavior	<input type="checkbox"/> Partner was supportive when asked to use condoms
Attitudes	General thoughts and feelings about a current behavior or new behavior	<input type="checkbox"/> Thinks condoms are always uncomfortable (negative attitude) <input type="checkbox"/> Believes condoms are effective protection (positive attitude)
Intentions	What one intends to do in the future	<input type="checkbox"/> Plans to use condoms tonight
Social Norms	What one believes that people important to him/her want him/her to do	<input type="checkbox"/> Believes that his/her parents want him/her to "be safe"
Policy	Laws and Regulations affecting a behavior	<input type="checkbox"/> No distribution of condoms in school

## **An Autobiography in Five Chapters**

### **Chapter One:**

I walked down the street  
There was a deep hole in the sidewalk  
I fell in  
I am lost... I am hopeless  
It is not my fault  
It takes forever to find a way out

### **Chapter Two:**

I walked down the same street  
There was a deep hole in the sidewalk  
I pretend I do not see it  
I fell in, again  
I cannot believe that I am in the same place  
But, it is not my fault  
It still takes me a long time to find a way out

### **Chapter Three:**

I walked down the same street  
There was a deep hole in the sidewalk  
I see it there  
I fall in...It is a habit...but my eyes are open I  
cannot believe that I am in the same place I  
know where I am  
It is my fault  
I get out immediately

### **Chapter Four:**

I walked down the same street  
There was a deep hole in the sidewalk  
I walk around it

### **Chapter Five:**

I walked down a different street

- ☐ How can you relate this book to a personalized prevention plan?

## **SUMMARY - PERSONALIZING BEHAVIOR CHANGE**

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### **CDC Standards for HIV Prevention Counseling**

1. Establish and/or improve the client's self-perception of risk.
2. Identify and support behavior changes the client has already attempted.
3. Negotiate a realistic and incremental plan for reducing or eliminating risk.

### **Counseling Model of Behavior Change**

1. KNOWLEDGE AWARENESS - The client must have information about HIV risk.
2. SELF-EFFICACY - The client needs to know the relationship of the behavior change to his/her self-regard and personal values. (What kind of decisions does a client make for self?)
3. SIGNIFICANCE TO SELF (PERSONALIZING THE RISK) - Of what significance is this behavior change to the client? How does it relate to his/her daily activities?
4. COST/BENEFIT ANALYSIS - What will this change in behavior cost the client? What will be the benefits if the client changes his/her behavior?
5. CAPACITY-BUILDING - The client needs support for the expected changes in his/her behavior. They will need a friend, family member or some other support mechanism. They need to know their own capacity for change.
6. PROVISIONAL TRY - The client may need to try the behavior change more than one time before he/she is willing to change. They will probably need to move incrementally toward change.
7. THE BEHAVIOR CHANGE - The expected outcome will be a reduction or elimination of the risk of HIV infection. The behavior change will be significant and personal to the client.

### **Factors that Affect Behavior Change**

1. KNOWLEDGE: Basic factual information of how one gets a disease and how to protect oneself from it
2. PERCEIVED RISK: Feeling vulnerable to a health risk
3. PERCEIVED CONSEQUENCES: What one believes will happen, either positive or negative, as a result of performing a new behavior
4. ACCESS: The existence, affordability, and accessibility of services and products needed to support a particular behavior
5. SKILLS: The abilities necessary to perform a particular behavior
6. SELF-EFFICACY: Belief or confidence that one can do a particular behavior
7. ACTUAL CONSEQUENCES: Actual experiences, both positive and negative, in doing a particular behavior
8. ATTITUDES: General thoughts and feelings about a current behavior or new behavior
9. SOCIAL NORMS: What one believes that people important to him/her want him/her to do
10. POLICY: Laws and regulations affecting a behavior

# ***CHAPTER 3***

## **Cultural Competency**

## CULTURAL COMPETENCY

A person's cultural background will influence what the individual considers a health problem or risk. It will also determine how symptoms and concerns are expressed and who provides treatment, as well as, what type of treatment is to be given. What is "real" is culturally defined. Knowledge and understanding of cultural perceptions of health and wellness are vital in provision of HIV prevention services to diverse populations at increased risk.

<b>Culture includes</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Thoughts</li> <li><input type="checkbox"/> Communications (verbal, nonverbal, literary)</li> <li><input type="checkbox"/> Actions</li> <li><input type="checkbox"/> Customs</li> <li><input type="checkbox"/> Beliefs</li> <li><input type="checkbox"/> Values</li> <li><input type="checkbox"/> Institutions</li> </ul>	<b>Elements of culture</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Created through interactions</li> <li><input type="checkbox"/> Passed through generations</li> <li><input type="checkbox"/> Learned</li> <li><input type="checkbox"/> Not frequently discussed</li> <li><input type="checkbox"/> Provides further explanations</li> <li><input type="checkbox"/> Dynamic</li> <li><input type="checkbox"/> Difficult to change</li> <li><input type="checkbox"/> Source of emotional responses</li> </ul>
<b>Cultural factors</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Objective – The visible aspects of culture (food, clothing, art, music, dance)</li> <li><input type="checkbox"/> Subjective – The less tangible aspects of culture (values, norms, expectations, beliefs)</li> </ul>	<b>Variations within cultural groups</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ethnicity</li> <li><input type="checkbox"/> Age</li> <li><input type="checkbox"/> Socioeconomic status</li> <li><input type="checkbox"/> Religion</li> <li><input type="checkbox"/> Education</li> <li><input type="checkbox"/> Language</li> <li><input type="checkbox"/> Gender</li> <li><input type="checkbox"/> Sexual Orientation</li> <li><input type="checkbox"/> Length of time in the U.S.</li> <li><input type="checkbox"/> Urban vs. Rural</li> <li><input type="checkbox"/> Contact with elders</li> </ul>

### Points to Remember about Culture

1. What seems logical, sensible, important, and reasonable to a person in one culture may seem irrational, stupid, and unimportant to an outsider.
2. Feelings of apprehension, loneliness, and lack of confidence are common when visiting another culture.
3. When people talk about cultures, they tend to describe the differences not the similarities.
4. It requires experience as well as study to understand the many subtleties of another culture.
5. Understanding another culture is an ongoing process.

**Cultural competence** is the desire, skills, and knowledge necessary to enable organizations, systems, and/or individuals to work effectively, and provide services consistent with the cultural context of the client. It is the:

- ☐ Awareness and acceptance of cultural differences
- ☐ Awareness of one's own cultural values
- ☐ Understanding that people of different cultures have different ways of communicating, behaving, and problem solving
- ☐ Having basic knowledge about a client's culture
- ☐ Ability and willingness to adapt the way one works to fit the client's cultural background.

**Cultural competence is not:**

- ☐ Being politically correct
- ☐ A bandage on the problem
- ☐ Memorizing beliefs, knowledge, and practices of cultural groups
- ☐ Forcing one's own cultural practices and beliefs onto another group
- ☐ The same as Equal Employment Opportunity and Affirmative Action.

**Lack of cultural competence leads to:**

- ☐ Clients receiving poor care
- ☐ Lack of client compliance
- ☐ Lack of client satisfaction
- ☐ Lack of community support
- ☐ Worsening health status of the clients.

Culturally competent agencies are more effective because they understand and respond to the needs of the populations served. They also reflect the population served in staffing and environment. Culturally competent agencies also value employees and involve them in the decision making process, and balance the needs of the organization, employees and population served.

**Just collecting this information is not enough. It must be incorporated and used to guide services to better meet the needs of the clients' from their cultural perspective. This information must also be made available to and shared with others.**

## **Characteristics of the Culturally Skilled Counselor**

- ☐ The counselor is aware of his/her own assumptions, values, and biases and:
  - ☐ Has moved from being culturally aware to being aware and sensitive to his/her own cultural heritage and to valuing and respecting differences
  - ☐ Is aware of how they may affect clients from culturally diverse backgrounds
  - ☐ Is comfortable with differences that exist between themselves and their clients in terms of race, culture, and beliefs
  - ☐ Is sensitive to circumstances that may dictate referral or linkage of clients to a member of his/her own race/culture or to another provider
  - ☐ Acknowledges his/her own cultural attitudes, beliefs, and feelings.
- ☐ The counselor understands the need to acquire and develop appropriate strategies and skills and:
  - ☐ Recognizes the need to develop and adapt a new set of approaches in order to be able to provide appropriate services for clients of diverse cultural backgrounds
  - ☐ Is able to generate, send and receive a wide variety of appropriate and accurate verbal and nonverbal messages
  - ☐ Is able to exercise institutional intervention skills on behalf of his/her client when appropriate
  - ☐ Is aware of his/her helping style, recognizes the limitations he/she possesses, and can anticipate the impact on patients from different cultural backgrounds.

## **Knowledge, Skills, and Abilities Essential to Cultural Competence**

- ☐ Knowledge of...
  - ☐ The culture, history, traditions, values, and family systems of the culturally diverse clients
  - ☐ The impact of culture on the behaviors, attitudes, values, and health status of clients
  - ☐ The help-seeking behaviors of culturally diverse clients
  - ☐ The roles of language, speech patterns, and communication styles in culturally distinct communities
  - ☐ The social, environmental, and health plan policies on culturally diverse clients
  - ☐ The resources (for example, agencies, persons, and helping networks) which can be utilized on behalf of culturally diverse clients and communities

- ☐ Recognition of the ways in which professional values may conflict with or accommodate the needs of the culturally diverse clients.
- ☐ Skills in...
  - ☐ Personal qualities that reflect genuineness, empathy, warmth, and a capacity to respond flexibly to a range of possible situations
  - ☐ Acceptance of cultural differences between people
  - ☐ Explicit understanding of the employee's personal values, stereotypes, and biases about their own and another's culture
  - ☐ Techniques for learning and adapting to the personal cultural patterns of clients and their impact on adherence to prescribed intervention strategies
  - ☐ Capacity to work with family members and friends of clients in communicating the nature of health and environment conditions and recommended intervention strategies.
- ☐ Ability to...
  - ☐ Communicate accurate information on behalf of culturally diverse clients and communities
  - ☐ Discuss cultural differences and issues openly, and to respond to culturally-based cues
  - ☐ Assess the meaning culture has for individual clients
  - ☐ Interpret the implications of evidence of problems as they are expressed by clients from different cultures
  - ☐ Work effectively with an interpreter to obtain information from a client
  - ☐ Evaluate new techniques, research and knowledge regarding their application in working with culturally diverse clients
  - ☐ Secure an appropriate level of cooperation with strategies and services.

### **Steps to Becoming Culturally Competent**

1. Personal recognition and acceptance that all types of cultures have profound influences on our lives.
2. Personal awareness that oppression is pervasive in our society. It is part of our history and, as much as we may want to escape that fact, it colors our relationships.
3. The acceptance that there are cultural differences and we need to learn to respect what we may not always understand.
4. Have the humility to accept that we do not know everything about other cultures, and never will. We, therefore, need to ascertain what it is we need to know about the specific groups with whom we are working.
5. A willingness to pursue that information in all of the ways available to us.
6. When we are unable to do any of the above, having the courage to identify and confront our personal resistance, anger, and especially, our fears.

## **How to Find out More about a Particular Culture**

- ☐ Read written sources of information and data. Describe the community geographically in terms of the clients' perspective.
- ☐ Map the assets within the community.
- ☐ Seek out community input through ethnographic interviewing, focus groups, surveys, and talking with community members and clients. Observe the community and clients.
- ☐ Collect race specific data.
- ☐ Seek out input from others who have worked with the community and clients.

## **Hints on First-Time Contacts**

It can be difficult to counsel clients if you cannot gain accurate information on their situation. Typical problems include:

- ☐ Mistrust or having reservations until the questioner moves out of the "stranger" category
- ☐ Clients may tell you what they think you want to hear.
- ☐ You may be asking the wrong questions.
- ☐ People may have difficulty describing and explaining things that are second nature to them.

## **Suggestions for Enhancing Cultural Competency**

1. Avoid stereotyping by:
  - ☐ forming impressions too soon
  - ☐ drawing incompletely from conclusions before you understand the viewpoint of the client you are working with
  - ☐ generalizing from a non-typical client to the entire community
  - ☐ forgetting that individual variations exist within the community.
2. Use good HIV prevention counseling questions that allow clients to define the problem/issues in their own words.
3. Choose an interpreter who is trained and able to understand and respect the culture of the client and the health care professional. Try to avoid using family members if possible because they tend to censor what is said or shield information going back to the family member, or the client may not feel comfortable being completely honest in front of family. Stress confidentiality. Even if you don't speak the client's language, he or she will appreciate you making an effort to communicate.

4. Nonverbal communication is important. Take note of what your and the client's body is saying. Facial expressions, gestures, body movements, and even silence communicate meaning, which varies among cultures. The following nonverbal communications are particularly important in transcultural communication:

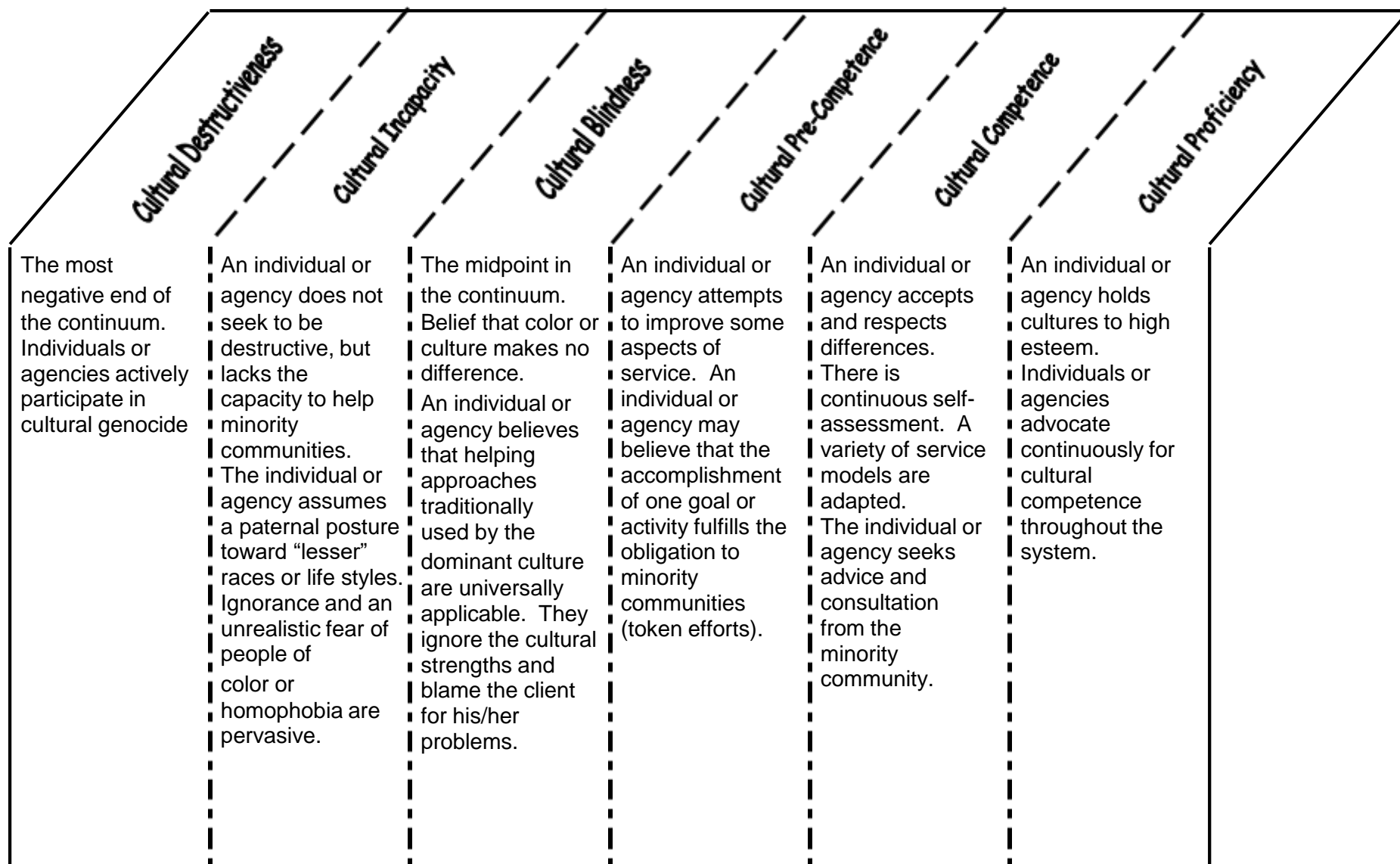
- **Eye contact** - Some cultures (e.g., Americans of Anglican descent; White Americans) emphasize maintenance of eye contact when speaking and listening. In many other cultures (Southeast Asian, Middle Eastern, African) it is considered disrespectful or impolite to look directly at the person who is speaking. A side-glance is more respectful especially if the speaker is older or in a position of authority.
- **Distance** - Americans of Anglican descent often prefer to have about 18 inches between them and another person during conversation. Hispanics, Italians, and Africans are comfortable at a closer distance. Invite your clients to choose a seat or allow them to suggest where you should sit in order to create the most comfortable distance.
- **Body movements** - Movements such as upturned palms of the hands, waving one's hand and pointing fingers or feet convey varying messages. Observe the clients for clues. Read about the cultural patterns of the specific culture and ask your clients to tell you what gestures should be avoided. Most persons like to share their cultural patterns if you present yourself as a learner.
- **Touch** - In general, gentle touch for Americans of Anglican descent usually conveys warmth and caring. Although this is similar in most cultures, there are cultural rules and gender differences regarding culturally sanctioned touch. In some Asian cultures, the head should not be touched because it is the seat of wisdom. In many Hispanics cultures, the head of the child should be touched when you admire the child in order to ward off "mal de ojo" (evil eye).
- **Silence** - Americans of Anglican descent often find silence hard to tolerate, whereas American Indians use silence very effectively in communication. Cultures that value silence learn to distinguish varying qualities of silence, which are hard for mainstream Americans to discern. Again, observe your clients' use of silence and learn its cultural meaning in order to enhance your communications.
- **Emotional expression** - Some cultures (North European, American Indians) value stoicism whereas other cultures (South European, Hispanics, African, Haitian) express emotion such as pain, joy and sorrow more openly. Asians smile or even laugh to mask other emotions.

Learning to understand these variations requires keen observation and an open inquisitive attitude and respect for cultural differences and similarities.

## **Culture-Related Terms**

<b>Acculturation</b>	merging of cultures as a result of prolonged contact
<b>Assimilation</b>	the process of “fitting in” to a new culture
<b>Cultural Relativism</b>	the attempt to understand another’s beliefs and behaviors in terms of that person’s culture
<b>Culture</b>	a dynamic pattern of learned behavior, values, expectation, beliefs, and artifacts that are held by a group of people. Everyone has culture or is part of a culture. Culture has no ranked scale. There is no good or bad culture. There are strengths in all cultures.
<b>Enculturation</b>	a process of learning as a child
<b>Ethnocentrism</b>	the belief that only one’s culture makes sense, espouses the right values, and represents the right and logical way to behave
<b>Ethnicity</b>	the sense of identification by members of a group that is distinctive based on national origin or unique cultural patterns. Every race has ethnic groups.
<b>Race</b>	a socially determined classification system usually based on physical characteristics

## CULTURAL COMPETENCE CONTINUUM





# ***CHAPTER 4***

## ***Special Populations/Situations***

## **SPECIAL POPULATIONS/SITUATIONS**

Many clients who are members of certain population groups or who are involved in particular activities or circumstances can present special challenges in HIV prevention services. Knowledge of, and effective communications with, clients of these groups is vital to supporting them in behavior change for HIV risk reduction. This unit will provide participants with an opportunity to increase awareness as it relates to HIV/AIDS issues in terms of:

- A.** Pregnancy
- B.** Domestic violence
- C.** Substance use/abuse
- D.** Repeat testers
- E.** Men who have sex with men (MSM)
- F.** 30+ age group
- G.** Youth
- H.** Homeless populations
- I.** Incarcerated populations
- J.** Vaccine trial participants
- K.** Occupational exposure
- L.** Testing in nontraditional settings

In addition to the specific information given for each population, here are some additional points to consider when counseling and testing:

- ☐ Provide linkages and referrals during pre-test counseling.
- ☐ Review linkages and referrals at post test counseling.
- ☐ Clarify the “window period”.
- ☐ Provide additional counseling to repeat testers in order to: 1) relay accurate information; 2) discuss underlying anxiety/reason for repeat testing; and 3) address current prevention needs.
- ☐ Talk about sex. Counseling with active drug users should include risk reduction planning related to sexual behavior. While many drug users may be concerned about their drug-related risk, they may in fact have greater sexual risk, which is often not addressed.

In this unit, participants will develop strategies to assist in counseling persons from various backgrounds that impact their perceptions of HIV/AIDS risks or that place them at particular risk.

## A. Pregnancy and HIV Testing

Pregnant women who are infected with HIV and receive no special prenatal care to address HIV prevention have an approximately 30 percent chance of passing the infection to their babies. That risk decreases to approximately 2 percent if the woman is given available medications during her pregnancy, labor, and delivery, and the infant receives zidovudine (ZVD) for six weeks after birth. A cesarean section may be recommended and the woman counseled to abstain from breastfeeding. The phenomenal success of protecting newborn babies is only possible if a woman knows her HIV status, hence the special emphasis on testing pregnant women as early as possible in their pregnancy and again at 28-32 weeks.

Florida law **requires** health care providers who attend pregnant women to **advise** the women that they will receive an HIV test when they do routine blood tests associated with initiating prenatal care. If a woman objects to HIV testing, she must sign a written statement of objection, which will be placed in her medical record. The client should be informed that knowing her HIV status could enable her to protect her unborn baby if she is found to be HIV infected. The knowledge that certain anti-HIV drugs could substantially lower the risk of transmission of HIV from infected females to their babies often motivates women to agree to HIV testing.

Should she decline to accept the HIV test, documentation should be made in her medical record. (An example of such documentation, the DH 3161 Statement of Objection Form is found in Section E: Resources. This form is required in Department of Health prenatal clinics). If testing is declined, the client should be encouraged to allow her baby to be tested after birth.

When discussing the option of HIV treatment during pregnancy, the counselor should refrain from clinical jargon regarding the use of antiretroviral medications (e.g., "Oral administration of 100 mg ZDV five times daily..."). It is important to remember that while one medical protocol was prescribed for one pregnant woman, another may have a different protocol based on her individual needs. It is sufficient to inform the client that anti-HIV drugs can substantially reduce the risk of HIV transmission during pregnancy. The client will need to consult with her physician about what treatments are currently available, the risks and benefits of those treatments, and what would be best suited for her.

When a pregnant woman tests HIV positive, she should be referred or linked to the **Healthy Start Care Coordination System**. (More information can be obtained from the **Family Health Line** at 1-800-451-BABY.) In addition to the standard post-test counseling session, the counselor should discuss:

- ☐ The benefits of anti-HIV therapy during pregnancy
- ☐ HIV transmission associated with breastfeeding; Even if the infant is not infected during pregnancy or childbirth, infected women may transmit the virus through their breast milk.
- ☐ Testing of her other children; Since we may not know how long the pregnant woman has been infected, it is possible she could have already passed HIV on to another child.
- ☐ Recommended linkages. These may include mental health services, social and support services, primary care, partner services, and substance abuse evaluation and treatment.

If the test result comes back negative, the client should be offered risk reduction counseling as outlined in this manual. It is imperative that she be reminded that it generally could take up to three months between exposure to HIV and testing positive for the antibodies.

Pregnant women with an indeterminate test should consider immediately being re-tested to rule out HIV infection. Regardless of the test result, a domestic violence assessment should be done by the counselor. (Refer to section on domestic violence.)

Additional updated guidelines on counseling and testing in pregnancy and the use of anti- HIV medication during pregnancy can be accessed at the AIDSinfo website: [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov). To order single copies of these guidelines, call the CDC's National Prevention Information Network at 1-800-348-5231.

## References

Morbidity and Mortality Weekly Report; Recommendations and Reports: November 9, 2001; 50 (RR19); 59-86; "Revised Recommendations for HIV Screening of Pregnant Women."

## B. Domestic Violence

Domestic abuse is a pattern of behaviors used to establish power and control over an intimate partner, often leading to the threat or use of violence. Abuse is any controlling, hurtful act, word, or gesture that injures another's body or emotions. Domestic abuse takes many forms and may escalate in severity. These forms demonstrate themselves as acts of domestic abuse and generally fall into one or more of the following categories:

- ☐ Psychological abuse may include emotional, verbal, and financial abuse and may be experienced as intimidation, terrorizing, name-calling, jealousy, destroying property, eliminating access to finances, threats directed toward other family members, children, or household pets.
- ☐ Sexual abuse may include denying privacy, forcing performance of sexual acts that are not comfortable, unwanted sexual touching, and/or partner rape.
- ☐ Physical abuse may include pushing, slapping, biting, kicking, hitting with objects, restraining, and/or the use of a weapon (<http://www.casa-stpete.org/101.html>).

Domestic violence affects millions of people in the United States each year. It has been connected to increased rates of substance abuse and risky sexual behaviors. As an HIV counselor, you are in a position to assist a client in preventing further abuse or in reducing his/her risk of abuse. **In some cases, you may be the only person to whom the client has ever disclosed his/her abusive relationship.** It is not your role to do domestic violence counseling. You cannot force an adult client to take action to deal with their violent situation. (In the case of elder and child abuse, you have more leeway in reporting abusive situations.) However, you are there to offer the client an opportunity to access linkage services.

Many people think of domestic violence only as the abuse of a female by her male sex partner. In fact, 95 percent of reported abuse victims are females. However, domestic violence occurs in same sex couples as it does in heterosexual couples. The terms domestic violence or domestic abuse also include the abuse of a male by a female partner or partner abuse within a male-male or female-female relationship. Questions and references about relationships should use terms such as “partner” rather than “husband/wife”, “boyfriend/girlfriend”, or “spouse”.

In 1995, the Florida legislature passed a bill requiring that information and referrals be provided by Florida’s HIV/AIDS program for those in need of domestic violence services. Since then, domestic violence has been addressed routinely as part of HIV pre- and post- test counseling. The Department of Health’s Technical Assistance: HIV/AIDS 9: Provision of HIV Prevention Counseling, Testing and Referral Services states that “counselors should also be sensitive to the issue of domestic violence and the effect domestic violence may have on the individual’s ability to negotiate safer sexual practices or willingness to

notify partners of possible exposure. Counselors should be aware of local shelters and make linkages and referrals as appropriate.”

Indicators of abuse may be physical or psychological. With physical indicators, the most common site of injuries is the head, face, neck and areas usually covered by clothing, such as the chest, breast and/or abdomen. Psychological indicators may include, but not be limited to, anxiety and panic disorder, depression, suicide attempts, and/or substance abuse.

In a clinic situation, other signs of abuse may be indicated when the client’s partner overtly displays jealousy, obsession or possessiveness of partner. The partner may insist on accompanying the client, answering all questions and/or refusing to leave the treatment area. Although educational materials should be available in waiting areas and examination rooms, be aware that providing the abused client with written material may increase his/her risk of abuse should his/her partner find such material.

Battered clients may appear frightened, ashamed, evasive or embarrassed, or they may appear perfectly normal. Counselors should be aware that a client’s family history, cultural background, and/or religious beliefs may also influence his/her perception of abuse. The Violence against Women Act has special provisions that address domestic violence in migrant populations. This information, along with other domestic violence legislation, may be accessed from the Florida Coalition against Domestic Violence website ([www.fcadv.org/](http://www.fcadv.org/)) or call 1-850-425-2749. Additionally, referrals for victim assistance can be made through the Florida Domestic Violence Hotline. (See below.)

It should also be noted that 50-60 percent of abusers come from homes where they were abused or witnessed abuse. They carry on the cycle of violence by abusing others. Anyone who is concerned about their abusive (or potential for abusive) behavior should contact the Florida Domestic Violence Hotline about getting into treatment.

### **Assessing the Client for Domestic Violence**

Domestic violence has a definite effect on the client’s decision to test for HIV, notification of the partner in the case of a positive test, and the ability of the abused client to adopt safer sexual practices. It is the role of the HIV counselor to assess for the presence of domestic violence and, if abuse is identified, assist the client in making the decision to test. Furthermore, the counselor should be familiar with the domestic violence services in the area and offer appropriate referrals and linkages.

When screening clients for domestic violence, the goal is to validate and empower the abuse survivor while attending to the immediate health concerns. Counselors should:

- ☐ Routinely screen all clients since domestic violence affects people from all backgrounds, income levels, and races.
- ☐ Screen clients in a confidential setting separate from their partner.
- ☐ Phrase questions in a nonjudgmental way.
- ☐ Provide an atmosphere where patients feel respected and taken seriously.
- ☐ Tell victims they do not deserve to be abused. Offer support and safety.
- ☐ Encourage victims to make their own choices and decisions.
- ☐ Assess their attitudes and perceptions regarding domestic violence (<http://www.casa-stpete.org/101.html>).

The approach used in making an assessment can vary, depending on the presence or absence of abuse indicators. If no abuse indicators are observable, the counselor may use a more generic approach. For example, the counselor could say: "Because violence is so common in many people's lives, we often ask clients about such abuse. What about such situations in your life?"

The appearance of abuse indicators may warrant a different approach. However, the question should be worded carefully so the client does not become defensive. An example of such an approach could be: "Sometimes when I see someone with an injury like yours, it is because someone hit them. What happened in your situation?"

Questions that the HIV counselor can ask a client in order to determine whether or not he/she is the victim of domestic violence includes:

- ☐ Does your partner know you are here today?
- ☐ How does he/she feel about you being tested?
- ☐ How would your partner react if your results came back positive?
- ☐ Has your partner ever forced you to have sex?
- ☐ How does your partner act when he/she drinks or uses drugs?
- ☐ Who makes the rules for sex between you and your partner?
- ☐ What does your partner do when he/she loses his/her temper?
- ☐ When was the last time your partner threw things at you or called you names?
- ☐ Does your partner prevent you from seeing friends or family members?
- ☐ Does your partner become jealous easily and watch your every move?
- ☐ Have you ever had to go to the hospital after a fight or argument with your partner?
- ☐ Are you afraid of your partner?

If, during a counseling session, the client discloses an abusive relationship assure the client that the abuse is NOT their fault. Treat the client with genuine warmth, respect, and like an adult. Reinforce confidentiality and provide reassurance. Try to assure the client that by coming forward and discussing the matter, he/she has done the right thing.

Also, inquire about the client's safety. Assist the client in making the decision whether or not to have the HIV test, or, if during a post-test positive, how to proceed with partner notification.

If the client is receptive, make appropriate linkages and referrals to include local domestic violence shelters, state attorney offices, and victim's assistance. Be sure not to identify any phone numbers given to the client as being that of domestic violence services. If the abuser found such information it could cause the violent situation to escalate.

A person in or at risk of a domestic violence situation could be facing additional risk if an abuser sees a needle track from where blood was drawn for HIV testing. The abuser could become accusatory and subsequently violent. A possibility for helping the client in that situation would be to do oral HIV antibody testing instead, and then proceed with offering domestic violence referrals for that client.

## **Indicators of Abuse**

### **Injuries**

- ☐ Most common site of injuries: head, face, neck, and areas usually covered by clothing, such as chest, breast, and abdomen
- ☐ Contusions, abrasions, lacerations, as well as fractures and sprains
- ☐ Eye and ear trauma
- ☐ Injury to multiple sites
- ☐ Injuries that don't fit with provided explanations
- ☐ Injuries in various stages of healing
- ☐ Injuries during pregnancy

### **Medical/Psychiatric Findings**

- ☐ Miscarriages and spontaneous or multiple abortions
- ☐ Pregnancy complications like placental separation, rupture of the uterus, and pre-term labor
- ☐ Gynecological problems, frequent vaginal and urinary tract infections, pelvic pain
- ☐ Pain with no visible sign of injury
- ☐ Chronic pain or headaches
- ☐ Anxiety disorder, depression, suicide attempts
- ☐ Post-traumatic stress disorder

### **Substance Abuse**

- ☐ Up to 50 percent of alcoholism in women may be precipitated by abuse.
- ☐ The use of drugs and alcohol increases dramatically after abuse begins.

- ☐ Research indicates that alcohol and drug abuse are likely consequences of abuse rather than causative factors.

### **Other Signs of Abuse**

- ☐ Noncompliance with prescribed treatment regimens
- ☐ Partner limits client's access to routine or emergency medical care.
- ☐ Inability to obtain or take medication
- ☐ Missed appointments
- ☐ Lack of independent transportation, access to finances or telephone
- ☐ Failure to use condoms or other contraceptive methods
- ☐ Client is reluctant to speak or disagree in front of partner
- ☐ Client of partner minimizes extent of injuries
- ☐ Overt displays of jealousy, obsession or possessiveness by partner
- ☐ Partner insists on accompanying client, answers all questions, and/or refuses to leave the treatment area.

Battered clients may appear frightened, ashamed, evasive, or embarrassed. They may appear perfectly normal. Counselors should be aware that a client's family history, cultural background, and/or religious beliefs may also influence his/her perception of abuse.

Victims of domestic violence stay with their abusers for many reasons including fear, economic dependence, depression, and the lack of a support system. Mothers may believe that they will lose custody of their children or that the children will be hurt if they leave.

Deciding to leave an abusive relationship is typically the most dangerous time for a victim, even if there has been no prior physical abuse. If clients indicate a reluctance to leave their partner immediately, then a safety plan should be reviewed. Remember to be supportive and not pressure clients if they are not ready at this point. Victims will typically consider leaving seven times before they leave for good.

It is imperative for the counselor to inquire about the client's safety. After assessing the situation, plans for the client's safety should be discussed before he/she leaves the facility. The following are options to be considered:

- ☐ Does the client have a support system such as a close friend or relative?
- ☐ Does the client want to return to his/her partner?
- ☐ Does the client want to proceed to the shelter immediately?
- ☐ If a shelter is available, can the client go to a shelter immediately? Give written information about what services are available only if it is safe to do so.

In general, the abused actively seek assistance from numerous sources to end the violence. These resources include law enforcement, attorneys, health care professionals, family

members, friends and clergy. Frequently, these individuals and systems fail to provide the needed support, and the abused person remains in a violent relationship.

### **Domestic Violence and the HIV-Positive Client**

Remember, risk assessment for domestic violence should be included as a routine part of HIV-seropositive client counseling. It should be recognized that all relationships have the potential for abuse. If an HIV-positive client is in an abusive relationship, the counselor must assess which method of partner notification will diminish the risk of violence to the client. It may be, at that time, the client is ready to access domestic violence services or proceed to a shelter.

In making arrangements for HIV-infected domestic violence victims, remember that discrimination based on HIV/AIDS status in matters such as housing, employment, state programs, and public accommodations (including hospitals and physician's offices) is illegal in Florida. It must be stressed that notifying an abusive partner about a client's HIV status could place the client in danger.

### **References**

Florida Coalition against Domestic Violence - <http://www.fcadv.org/>

Florida Domestic Violence Hotline: 1-800-500-1119

The James and Jennifer Harrell Center for the Study of Domestic Violence, The Harrell Center, University of South Florida - <http://harrellcenter.hsc.usf.edu>

### **C. Impaired Judgment & HIV Transmission - Substance Abuse/Use**

The most efficient means of transmitting HIV is through blood-to-blood contact. If enough HIV-infected blood gets into the body, infection may occur. However, a sufficient amount of HIV-infected blood must enter the bloodstream to cause infection. It may take as little as a few drops for infection to occur. History has shown that exposure of infected blood to intact skin (i.e., no open sores or lesions) has not transmitted the virus. However, **the chances of becoming infected from shooting drugs and sharing needles may be as high as 1 in 2 in some areas of the United States.**

### **Alcohol, Non-injection Drugs and HIV**

Shooting drugs and sharing needles is certainly a behavior that puts an individual at risk for transmitting or acquiring HIV. Substance abusers who do not use injectable drugs are also at high risk of infection. Substance abuse and HIV goes beyond the issue of needles. People who abuse alcohol, speed, crack cocaine, poppers or other non-injected drugs are

more likely than non-substance users to be HIV positive or to become seropositive. People with a history of non-injection substance abuse contribute to the spread of the epidemic when users trade sex for drugs or money, or when they engage in risky sexual behaviors they might not engage in when sober.

Since the middle to late 1980s, crack cocaine has been the drug of choice for many drug users in communities across America. Although the act of smoking the drug does not put a person directly at risk, the behavior that may accompany the drug use could. Pipes and paraphernalia could also transmit the virus due to sharp edges (and thus possible breakage of the mucous membrane in the mouth) from crude hand made pipes. Furthermore, many crack users may have oral lesions and/or blisters caused by the hot temperature of the pipe. (This could facilitate HIV transmission through oral sexual contact.) Individuals in many communities who are addicted to crack cocaine support the cost of their addiction by having sex in exchange for the drug or money. In the course of a single day, these addicts may each have several sexual partners and may not be in a state of mind to think about using any type of barrier protection (like condoms) against HIV or other sexually transmitted diseases.

There are probably a lot of reasons why substance abusers are at higher risk for HIV. The reasons most likely vary by drug and social context: crack abusers may have different risks than alcohol abusers, for example. For non-injecting substance abusers, HIV infection is not caused by drug use but by unsafe sexual behavior.

“Street drugs” such as marijuana (“pot”), ecstasy (“X”), crystal methamphetamine, and ketamine (“K”; “Special K”), may impair good judgment when it comes to having safe sex. Gamma hydroxy butyrate (GHB) is associated with “date rape”. The clear, odorless liquid is placed in an unsuspecting person’s drink. After they pass out, they may awaken to the realization they were raped during their unconscious period. A similar event can occur with the use of Rohypnol – “roofies” or “the forget pills”. Without the ability to think clearly, sexual contact may take place (with no thought of using barrier protection) and body fluids may be exchanged. It is possible for HIV transmission to occur after one single sexual contact with an infected person, even if you were unconscious during the contact.

The abuse of legal drugs may cause a similar prevention problem. Good judgment is often impaired during this type of substance abuse, and any measures to prevent the transmission of HIV by the individual may go by the wayside. Being drunk with alcohol may help cause a person to do things they would not do if they were sober and in control of their senses. Prescription analgesics (such as Oxycontin) or sedatives (such as Valium or Xanax) may, if used improperly, have a similar effect. If a person's inhibitions are reduced and his/her guard is down during a prescription drug induced high, sexual contact could take place with an infected person without barrier protection, and transmission could occur.

Some terms to remember in the discussion of impaired judgment and HIV transmission are:

- ☐ **Direct Transmission:** Direct sexual contact with people infected with HIV who have IDU and/or alcohol histories
- ☐ **Indirect Transmission:** Sex partner of a person who has had unprotected sex with an IDU infected with HIV; Babies born to sex partners of IDU with HIV
- ☐ **Impairment:** Drugs and alcohol can cloud a person's judgmental capacity. They may make a person more apt to do things he/she wouldn't normally do...such as have sex without using a condom. A person might not clean his/her needles/syringes properly.
- ☐ **Co-Factor:** Alcohol and drug use can assist HIV in progressing quicker in the body. The unhealthy life style associated with alcohol and drug use can also assist in the progression of HIV.
- ☐ **Denial:** Many people who have a drinking problem or abuse mood-altering prescription drugs may not acknowledge it. For example, they may have blackouts and not remember what they have done.

## Injecting Substances

Substances may be injected four ways by injection drug users (IDUs):

1. Subcutaneous (a.k.a. "Sub Q", "Popping"): piercing the skin, but not as far as the muscle
2. Intramuscular (a.k.a. "IM"): piercing the skin into the muscle
3. Deep Intramuscular (a.k.a. "Deep IM"): longer needle used, piercing deeper into the muscle
4. Intravenous (a.k.a. "IV"): into the vein.

If a person injects drugs and shares needles, they are engaging in a behavior that puts them at increased risk for HIV. Counselors must be as knowledgeable and comfortable talking about injection drug use and needle-sharing behavior as they are discussing sexual behavior.

Any type of needle sharing may transmit HIV. If an infected body-builder injects anabolic steroids then shares the needle with someone else, the virus may be transmitted. It is not just heroin, cocaine, or some other street injecting drug use that transmits HIV. Sharing tattoo needles or needles for ear and/or body piercing may be a means of transmitting HIV. Sharing contaminated needles has resulted in the second highest number of reported AIDS cases (behind sexual contact) in the United States.

Most Americans who are infected through blood-to-blood contact have become infected through sharing infected needles, syringes, and injection drug use equipment. Many times

this involves illicit drugs (heroin, etc.), but not always. It can involve injecting prescription drugs, whether injected by the person they are prescribed for or someone else. Injection drug use equipment, including syringes, needles, cotton balls, water, etc. should never be shared.

To assess a client's needle use, the counselor must initiate a conversation with clients about needle sharing practices, asking the client directly when the topic of drug use comes up. Anytime a client says that he/she uses injectable drugs, ask about needle use. Once needle use is established, it is helpful to ask open-ended questions about the client's risk behaviors and knowledge of HIV risk. For example, the counselor could ask "How would you assess your level of risk for HIV infection?"

When working with injection drug-using clients, counselors often focus exclusively on needle sharing, but these clients are often at risk for HIV through unprotected sex. It is important for counselors to assess all of the HIV risk behaviors in which a client engages. Although heroin does not act as a sexual stimulant, it is common for heroin users to take another substance, either simultaneously with heroin or at other times, and some of these substances, such as methamphetamines, may act as sexual stimulants.

Sometimes sex is a way to suppress dependence on heroin or other drugs. This may be true for sex workers as well as for people who exchange sex for drugs. Although these cases present difficult situations, often without clear or realistic solutions, discussing harm reduction approaches may provide clients with options. Work with clients to increase frequency of condom use, but recognize that, for a variety of reasons, condom use may be difficult to initiate.

If clients are using drugs, abstinence and not sharing equipment are the only sure ways for them to protect themselves. Unfortunately, that may not be a very realistic option if that person has a drug addiction. If he/she does have a drug addiction, he/she may at one point or another choose to seek treatment. Understand that may not be a very realistic option because the waiting list at some facilities may be several months long. It is also very difficult for many clients to just go "cold turkey." There are also some people who do not want to seek treatment for one reason or another.

For IDUs who cannot or will not stop injecting drugs, or are waiting to get into a drug treatment facility, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission. They must be advised to always use sterile injection equipment; warned never to reuse needles, syringes, and other injection equipment; and told that using syringes that have been cleaned with bleach or other disinfectants are not as safe as using new sterile syringes.

Needles and syringes can be cleaned in the following manner:

1. three times with water
2. three times with bleach
3. three times with water.

- ☐ Use two cups, one for the bleach and one for the water.
- ☐ Fill the syringe completely each time.
- ☐ Hold the liquid in the syringe each time for 30 seconds.
- ☐ Tap on the syringe each time it is filled to loosen any particles of drug or blood.
- ☐ Expel the liquid from the syringe onto the ground, not back into the cups.
- ☐ Do not share wash water, "works", cooker or cotton balls.

Remember: This procedure does not sterilize the needle and/or syringe. It merely cleans them.

If the user is unable to obtain any of the above-mentioned liquids for cleaning the needles and syringes, an alternative is to just use water. The water should be used for a minimum of 10 times, starting out with cold water and then with water as hot as possible and then back to cold. Needles and syringes can also be boiled for at least ten minutes, but this can destroy some of the plastic parts of the needle and the syringe. Please note that the preferred and best way to clean needles and syringes is with bleach and water. The least effective way is to simply rinse the needle or syringe with any liquid, such as tap water, rainwater, soda or any drinkable liquid. Some measure of prevention is better than no measure at all.

#### Mixing/Rinsing - Filters, Glasses, Spoons, and Water

Any equipment that can be used for mixing the drug, or rinsing the needle or syringe, can also possibly pass HIV or other illnesses through contaminated blood.

#### Filters, Glasses, and Spoons

If glasses or spoons have been used before, make sure that they are cleaned the same way that the needles and syringes are cleaned: rinsed three times with water, three times with bleach, then three times with water. This method is best if done right before use.

Injection drug users should try not to use cigarette filters. Some of them contain tiny glass fragments which can damage veins, heart, and other parts of the body. Use regular cotton or a part of an unused tampon instead.

#### Water for Mixing or Rinsing

Mixing the drugs with sterile water is best. If there is no sterile water, boiled water is the next best type to use. Do not use hot water from the tap or water that has been sitting around for a while.

### Dividing Hits

It is important not to share a “hit” (drug) by dividing it between two individuals and sharing it. Blood from the first person will be on the needle, in the syringe, and mixed with the drug.

### **Needle Exchange Programs**

Needle exchange programs are in effect in some areas of the country. (At the time this manual was printed, there were no legally operating needle exchange programs in Florida.) These programs allow injecting drug users to bring in their used needles and exchange them for new, sterile needles. Various studies have shown that these projects may help reduce HIV transmission. The concept, however, is still very controversial in the political arena.

### **Handling Used Needles & Syringes Safely**

An injection drug user (or anyone, for that matter) can easily get stuck or scratched with a needle that has been left out. If there is a needle stick or scratch, it is important not to panic. The area where the stick/scratch occurred should be washed with soap and water as soon as possible. Later, it should be covered with a clean bandage/Band-Aid.

Needle stick risks are reduced when used needles are properly disposed (such as putting them in an impermeable container). It is also important to never recap needles and syringes. Many people have been stuck this way.

### **Reference**

National Clearinghouse for Alcohol and Drug Information (A Service of the Substance Abuse and Mental Health Services Administration); website:  
<http://www.health.org>.

## **D. Repeat Testers**

Persons who have tested negative for HIV will, in general, not be infected with the virus. However, because it may take, on average, up to three months for the antibodies to adequately develop, re-testing may be warranted if the client was recently exposed to HIV.

Persons with continued HIV risk behavior pose a special challenge for follow-up testing. Their current risk behavior might be reinforced by repeated negative HIV test results (“I’ve been lucky so far, so why not keep doing what I’m doing?”). The client might even view HIV testing to be, in itself, protective (“I get tested every six months”). This scenario would present the counselor with the opportunity to ask the client what he/she is doing to protect him/herself during those six-month intervals. It might be appropriate to remind the client that once they are infected with HIV, it will be permanent.

In some settings, clients with ongoing risk represent a substantial proportion of those receiving HIV counseling, testing and linkage. In most circumstances, follow-up HIV testing should be recommended periodically for clients with ongoing risk behavior. Follow-up testing would monitor the client’s HIV status, but also promote continued client contact, opportunities for HIV prevention counseling, and linkage to additional preventive and support services.

Counselors should encourage clients to explore alternative prevention strategies and to identify and commit to additional risk-reduction steps. Clients with multiple and complex needs that affect their ability to adopt and sustain behaviors to reduce their risk for acquiring HIV should receive or be linked to an agency that offers prevention case management. Prevention case management can help coordinate diverse linkage and follow-up concerns. Pre-exposure Prophylaxis (PrEP) is a once-daily pill, taken orally, in conjunction with prevention strategies to reduce the risk of acquiring HIV infection. Currently, the only medication approved by the FDA for PrEP is tenofovir disoproxil fumarate (TDF) 300 mg co-formulated with emtricitabine (FTC) 200 mg, known as Truvada®. PrEP is recommended as a prevention option for individuals at higher risk of acquiring HIV infection, including adult men who have sex with men (MSM), high-risk adult heterosexually active men and women, adult injection drug users (IDU), and adults whose partners are known to be HIV infected. A series of clinical trials have demonstrated the effectiveness of PrEP. The guidelines are based on strong evidence from PrEP clinical trials that were conducted in high-risk populations. These studies did not find any significant safety concerns with daily use of PrEP.

More information on Comprehensive Risk Counseling and Services (CRCS) is available in the CDC’s “HIV Prevention Case Management Guidance (August, 2006). The entire booklet can be downloaded from the internet at

[http://www.cdc.gov/hiv/topics/prev\\_prog/CRCS/resources/CRCS\\_Manual/index.htm](http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources/CRCS_Manual/index.htm)

## E. Men Who Have Sex with Men/Gay/Bisexual/Transgendered

The gay community is as diverse as any other population; the needs vary depending on the individual. From newly self-identified gay youth to men who have sex with men that do not admit or acknowledge their behavior, these individuals come with a unique set of HIV risk behaviors that must be dealt with accordingly. Health departments and CBOs should develop strategies to increase knowledge of HIV status among MSM. They should work with the MSM communities to develop valid messages that stress the client benefits of HIV and STD testing. Strategies also need to be developed to increase the proportion of HIV-infected MSM who are linked to appropriate care and prevention services. Health departments and CBOs should enhance linkages to organizations that provide HIV-related care, so that men who test positive are successfully linked into care networks that are sensitive and attuned to their particular prevention needs.

Terms To Be Familiar With	
<input type="checkbox"/> <b>Androgyne</b>	Person appearing and identifying as neither man nor woman, presenting a gender either mixed or neutral
<input type="checkbox"/> <b>Bisexual</b>	Erotic, romantic, and affectional attraction toward both sexes
<input type="checkbox"/> <b>Butch</b>	Masculine-appearing person
<input type="checkbox"/> <b>Cross dresser</b>	Someone who enjoys dressing as a member of the gender "opposite" from his or her birth gender, but has no desire to change his or her sex permanently. Cross dressing is one form of being transgendered. Polite term for transvestite
<input type="checkbox"/> <b>Down low (DL)</b>	A man who may have sex with other men, but does not identify as gay or bisexual, and may not admit to the behavior.
<input type="checkbox"/> <b>Drag King</b>	Male-emulating woman
<input type="checkbox"/> <b>Drag Queen</b>	Female-emulating male, usually campy, often (not always) gay
<input type="checkbox"/> <b>Femme</b>	Feminine-appearing person
<input type="checkbox"/> <b>Gay</b>	Of, relating to, or used by homosexuals, "the gay rights movement", "a gay bar". This term is used to convey association with a specific culture or community.
<input type="checkbox"/> <b>Homophobia</b>	Irrational hatred and fear of lesbian and gay people that is produced by institutionalized biases in a society or culture. Several studies indicate that exposure to truthful information about lesbians and gay men often lead to a reduction in homophobia.
<input type="checkbox"/> <b>Heterosexism</b>	Institutional and societal reinforcement of heterosexuality as the privileged and powerful norm
<input type="checkbox"/> <b>Homosexual</b>	Erotic, romantic, and affectional attraction toward the same sex. Neither the term heterosexuality nor the term homosexuality existed before 1890.

<b>Terms To Be Familiar With (continued)</b>	
<input type="checkbox"/> <b>Intersex</b>	Person born with mixed sexual physiology. Often 'assigned' at birth, such practice is coming under attack as a hurtful violation of a person's well being.
<input type="checkbox"/> <b>MSM</b>	Men who have sex with men. Term used to separate the behavior from the identity. Not all men who have sex with men identify as gay or bisexual; or even admit to the behavior.
<input type="checkbox"/> <b>Same gender loving</b>	Gay, lesbian, or MSM
<input type="checkbox"/> <b>Sexual identity</b>	Inner-sense of oneself as a sexual being, including how one identifies in terms of gender and sexual orientation.
<input type="checkbox"/> <b>Sexual orientation</b>	One's erotic, romantic, and affectional attraction to the same gender (sex), to the opposite gender (sex), or both.
<input type="checkbox"/> <b>Sexual preference</b>	A term once used to describe sexual orientation--bisexuality, homosexuality and heterosexuality--which is now outdated because sexual orientation is no longer commonly considered to be one's conscious individual preference or choice, but is instead thought to be formed by a complicated network of social, cultural, biological, economic, and political factors.
<input type="checkbox"/> <b>Transgender</b>	<p>Exhibiting the appearance and behavioral characteristics of the opposite sex. A transgender person is someone whose gender display, at least sometimes, runs contrary to what other people in the same culture would normally expect. Gender variations are more common than most people suspect, because many people hide their true nature out of fear for their safety and security. Many people who explore transgender behavior do not identify themselves as transgender. Women wearing pants may not seem transgender today, but fifty years ago they were. Boys wearing "girl's clothes" might not call themselves "transgender", yet they enjoy playing in this way. Cross dressing is enjoyed by both males and females, but appears more pronounced in males because of an imbalance in norms of attire and attitude (we see less transgression when a woman wears a suit). Transgender persons can be of several types:</p> <ul style="list-style-type: none"> <li>• <b>FTM (female to male)</b>: born female but see themselves as partly to fully masculine.</li> <li>• <b>MTF (male to female)</b>: born male but see themselves as partly to fully feminine.</li> <li>• <b>Intersexed</b>: born with a combination of male and female physiology [similar to hermaphrodite or psuedohermaphrodite]. May accept as natural their mixed gender.</li> </ul>

<b>Terms To Be Familiar With (continued)</b>	
<input type="checkbox"/> <b>Transgender Community</b>	A loose association of people who transgress gender norms in a wide variety of ways. Celebrating a recently born self-awareness, this community is growing fast across all lines, including social, economic, political, and philosophical divisions. The central ethic of this community is unconditional acceptance of individual exercise of freedoms, including gender and sexual identity and orientation.
<input type="checkbox"/> <b>Transgenderist</b>	Person who lives as gender opposite to anatomical sex, i.e., person with a penis living as woman. Sexual orientation varies.
<input type="checkbox"/> <b>Transsexual</b>	A person with a psychological urge to belong to the opposite sex that may be carried to the point of undergoing surgery to modify the sex organs to mimic the opposite sex. Transsexuals feel "in their soul" that they are the opposite sex. They feel at odds with their own body. Many will cross dress to feel more comfortable, but this is a temporary remedy. Some will undergo SRS (sexual reassignment surgery) or hormone treatment, others simply live full- time cross dressed. Sexual orientation varies.
<input type="checkbox"/> <b>Transvestite</b>	Person who enjoys wearing clothes identified with the opposite gender. They are often, but not always, straight.

## Origins and Characteristics of Sexual Orientation

No single scientific theory about what causes sexual orientation has been suitably substantiated. Studies to associate sexual orientation exclusively with genetic, hormonal, and environmental factors have so far been inconclusive. Many interventions aimed at changing the sexual orientation of lesbians and gay men have succeeded only in reducing sexual behavior and self-esteem rather than in creating or increasing attractions to the other gender. The American Psychiatric Association removed homosexuality from its list of disorders in 1973. It is considered ethically questionable by the professional psychological community to seek to alter through therapy a trait that is not a disorder and is extremely important to individual identity and sexual health.

A common false allegation leveled against many gay men and lesbians is that they are child-molesters. In fact, heterosexual men commit 95 percent of all reported incidents of child sexual abuse.

## What is Sexual Orientation?

Our sexual orientation is who we are attracted to - it is not a choice we make. You may be bisexual, or attracted to people of both sexes. You may be heterosexual, or attracted to people of the other sex. You may be homosexual (often called lesbian or gay), or attracted to people of your same sex. For many young people, exploring their sexuality with someone

of the same sex is a natural part of growing up. These normal feelings may continue through their adult lives. A lot of people think that some sexual activities are just for heterosexual people, or that others are just for lesbians and gay men. The truth is that all people, regardless of their sexual orientation, may do all things. The difference is that gay men and lesbians do these activities with people of the same sex as themselves. Bisexual people do these activities with people of either sex. Heterosexual people do these activities with people of the opposite sex. Lesbian and gay relationships, like heterosexual relationships, can be fulfilling and can last a lifetime. All of these sexual orientations are part of being human.

### **Sexual Orientation vs. Sexual Identity**

Sexual orientation, gender identity, and sexual identity are independent of each other. A person may express any variation of each of these in any combination. **Sexual Orientation** is which sex you find erotically attractive: opposite (hetero), same (homo), or both (bi). **Sexual Identity** is how you see yourself physically: male, female, or in between. If someone is born female, but wishes to see their body as male in all respects, their sexual identity is male. We call such a person a transsexual, whether or not they have had any surgery. **Gender Identity** is how you see yourself socially: man, woman, or a combination of both. One may have a penis but prefer to relate socially as a woman, or one may have a vagina but prefer to relate as a man. One might prefer to be fluid, relating sometimes as a man and sometimes as a woman. One might not identify as either one, relating androgynously. People tend to categorize themselves.

### **Stages of Homosexual Identity Development**

<b>Sensitization:</b>	Before puberty children experience feelings of being “different” from peers, based on gender-neutral or atypical gender role choices or behaviors. Few see themselves as sexually different before age 12.
<b>Identity Confusion:</b>	After puberty, adolescents become aware of same-sex thoughts and feelings. Negative stereotypes of homosexuality lead to cognitive dissonance and confusion as adolescents struggle to make sense of their emerging identity. Lack of accurate information about homosexuality or positive lesbian/gay role models increases isolation and confusion. Adolescents respond by developing coping behaviors and usually hide their sexual identity or may adopt a bisexual identity.

### **Stages of Homosexual Identity Development (continued)**

<b>Identity Assumption:</b>	During mid to late adolescence or early adulthood, youth begin to self-identify and disclose their identity (come out) to other gay people. Over a period of several years, they interact with lesbian and gay peers. Positive experiences strengthen self-esteem and dispel negative stereotypes. Access to an organized lesbian/gay community provides opportunities for socialization and for developing relationships and finding positive role models. Youth learn a variety of strategies to manage their stigmatized identity.
<b>Commitment:</b>	Self-acceptance generally culminates with incorporating sexual identity into all aspects of one's life, usually during adulthood. Sexual identity is shared increasingly with non-gay friends and close family members. However, not all lesbians and gay males consolidate identity. Integration depends on various factors, including access to support and positive role models, personal strengths and vulnerabilities, and experiences with discrimination.

### **Understanding Men who have Sex with Men Subgroups**

Not all MSM are created equal. MSM sub-populations like “down low”, “trade”, “butch queen”, and “transgender” bring with them their own individual needs. The best ways to learn about them and find out what their prevention needs are is to talk with them. In addition, the self-identity (or lack thereof) that the client has accepted will determine which if any message they will hear. It is important to never presume the sexual identity and/or orientation of an individual. It is easy to alienate a client by assuming their orientation. Using labels like “gay” or “bi” can inadvertently convey a community attachment that not all individuals identify with.

However, regardless of the label used there are specific domains that affect the risk-taking behavior of MSMs:

- ☐ the extent to which the person is “out” to themselves and their community
- ☐ the extent to which there is family acceptance
- ☐ the extent to which the person is satisfied with their life
- ☐ the extent to which the person has connection to peers
- ☐ the extent to which the person has a positive gay role model.

Keeping these in context will help the counselor better identify the client's personal risk behaviors and circumstances, as well as, identify safer goal behaviors.

## **MSM of African Decent**

HIV/AIDS has had a disproportionate impact on racial/ethnic minority MSM, especially blacks and Hispanics. Race/ethnicity itself is not a risk factor for HIV infection. However, among racial/ethnic minority MSM, social and economic factors including homophobia, high rates of poverty and unemployment, and lack of access to prevention services and health care may serve as barriers to receiving HIV prevention information or accessing HIV testing, diagnosis, and treatment.

Of particular concern are the “non-identified” MSM. Often referred to as being on the “down low” (DL), these men put their unsuspecting partners at risk by committing acts that they do not own up to. Men on the DL compromise the health status of both their male and female partners by lying to both about their behavior and often not using protection. Regardless of race, men who call themselves heterosexual, but are involved in secret sexual relationships with men, are contributing to the rising incidence of HIV infection among women.

Often programs that target MSMs truly target gay men. This deters people who are not gay-identified from participating. In reality, true MSMs are not targeted, the non-identified man is missed.

## **Young MSM**

Young men who have sex with men, regardless of label or community attachment, bring their own particular brand of needs to the table. Often times, the sexuality of youth is taken for granted and a supportive outlet is rarely present. There needs to be a safe place for lesbian, gay, bisexual, transgender, and questioning youth to interact with each other, as well as positive role models. Transgendered youth are particularly disenfranchised. They need to be recognized and given a safe space. Overall, lesbian, gay, bisexual, transgender, and questioning youth suffer from a severe lack of services. When addressing HIV prevention, it is important to realize that the attention span of youth is limited, so interventions need to be dynamic. Though most youth have grown up with the reality of HIV/AIDS, misconceptions about the disease and their risks are blatant. The counselor must be sure to clear up any mistaken beliefs about HIV when counseling youth.

## **Issues in Prevention Counseling**

One of the main problems affecting the gay community is “prevention burnout.” Twenty- five plus years into the HIV epidemic, many older men who adopted safer sex practices in response to the initial health crisis, are finding it more difficult to maintain these practices indefinitely. Meanwhile, younger MSM – many of whom have never been

personally, affected by HIV – are also finding it challenging to practice safer sex every time.

Another concern includes the false sense of security brought on by new HIV/AIDS treatments. The availability of effective antiretroviral therapy, and the fact that HIV- positive people are living longer and healthier lives, has created the misleading perception that HIV is no longer a major health threat and has helped to create a sense among some gay men that the “crisis” is over. Some incorrectly believe that a reduced viral load means that someone is no longer infectious, which has made some gay and bisexual men less vigilant about maintaining safer sexual practices. However, the fact remains that despite important medical advances, HIV remains an infectious, life-threatening disease that requires complex, costly, and difficult treatment regimens that do not work for everyone.

## **Reference**

Gay/Lesbian/Bisexual/Transgender Health Webpages; Website:  
[www.metrokc.gov/health/glbtc](http://www.metrokc.gov/health/glbtc). (A service of the Seattle and King County Public Health Department).

## **F. Thirty (30) Plus Age Group**

Historically, adolescents and people in their twenties have received the most emphasis for encouraging HIV testing. When looking at statistics for reportable sexually transmitted diseases in Florida (year 2004, excluding HIV/AIDS), a large percentage of the infections occurred in people ages 15-29. It is clear that many people in this age group are putting themselves at risk for HIV.

However, AIDS and HIV cases reported through 2005 are less stark in contrast for similar age groups. Persons ages 13 through 29 account for only about 16 percent of the Florida AIDS cases. For HIV cases reported, the proportion is about 28 percent. Therefore, in roughly 84 percent of those AIDS cases (and about 72 percent of the HIV cases reported), the client is age 30 or above.

What is very surprising to many people is the impact HIV/AIDS has had on people over age 50 in our state. In Florida, with its large retirement community, the percentage of people older than 50 with AIDS is above the national average. In fact, 14 percent of cumulative AIDS cases in Florida were in the 50-plus age group; 12 percent of the HIV cases (not AIDS) were in that age group. (Actual rates of HIV infection itself are difficult to determine in senior adults since many in that age group are not routinely tested for the antibodies.)

Sexually active older people may be less likely to use condoms for various reasons. For example, if a female has completed menopause, she may not be concerned about using

barrier protection because she is not concerned about pregnancy. Ironically, older women may have more dryness in the vaginal area, which in turn could lead to more microscopic tears when having sex. This can provide a portal of entry for HIV to get to the blood stream.

Age differences may play a role in condom use. For example, a much older person may not think their younger sex partner has “been around” enough to be at high risk for HIV. As with other relationships, the older person may be concerned about losing the relationship if condom use is suggested.

Medical professionals may not consider HIV testing for older clients (particularly ages 50 and older). In part, this may be due to a physician’s unwillingness to discuss sexual and/or drug issues with older clients.

As an HIV counselor, it is imperative that you are willing to address, in a culturally sensitive manner, the issues of sexual and/or drug risks for older clients. The risk behaviors are the same regardless of the person’s age. Be aware that a person of one age (e.g., 65 years) may react differently to such topics than a person of another age (e.g., 21 years). These clients have probably had very different life experiences and have a different level of comfort in discussing intimate issues about themselves.

Clients who come to you for reasons unrelated to sexual or drug matters should, at a minimum, be assessed for HIV risk. This would include those coming for primary health care matters—diabetes, hypertension, high cholesterol, heart disease, etc. The issue of HIV testing can be introduced in a non-threatening manner. An example of such an approach could include the following:

“One of the services that we offer at our clinic is HIV testing. If you have never had an HIV test or have not had one in a long time, it may be very beneficial for you to be tested at this time, just to be on the safe side. I will be asking you some questions that may seem a little personal, but they will tell us your level of risk for HIV.”

Testing should be offered even if no risk is identified. If the client clearly expresses no interest in any HIV service, documentation should be made that the test was offered and declined.

## **References**

Senior HIV Intervention Project (SHIP); Broward County Health Department; State of Florida. Website: <http://www.browardchd.org/hiv.aspx>  
[http://www.doh.state.fl.us/disease\\_ctrl/aids/index.html](http://www.doh.state.fl.us/disease_ctrl/aids/index.html)  
Florida Department of Health website: [www.doh.state.fl.us](http://www.doh.state.fl.us) (HIV/AIDS “Trends and Statistics”; STD Control and Prevention “Trends and Statistics”).

## G. Addressing Issues of Youth

### Developmental Stages of Adolescents<sup>1</sup>

Developmental psychologists and health professionals have categorized adolescence into the following three developmental stages:

#### **Early Adolescence**

##### **Females**

Adolescent girls are much less likely to begin intercourse at this age. Of those who do, many are in relationships with much older men.

##### **Males**

Adolescent males may initiate intercourse during this stage, but most often delay sexual activity.

- ☐ These youth are often concrete thinkers and may have difficulty projecting themselves into the future.
- ☐ These youth are beginning to separate from the family, but usually value parental guidance on important issues.
- ☐ Peer norms and identification with particular groups become increasingly important at this stage.

#### **Middle Adolescence**

##### **Females & Males**

Sexuality and sexual expression are of major importance at this stage. As adolescents move through developmental changes, they often focus on themselves and assume others will equally focus on them.

Many middle adolescents choose to show off their new bodies with revealing clothes such as miniskirts and muscle shirts.

Sexual experimentation is common, and many adolescents first have intercourse in this stage.

- ☐ Many youth begin to develop abstract thought patterns.
- ☐ Youth in middle adolescence describe feelings of being “invincible”. This sense of invincibility, coupled with a developing ability to predict consequences, allows some adolescents to participate in risk-taking behaviors and believe they cannot be harmed while in this stage.
- ☐ As adolescents continue the process of separation from the family, they cling more tightly to their peer group. The desire to be accepted by the peer group often influences such issues as experimentation with drugs or sexual behaviors.

#### **Late Adolescence**

##### **Females & Males**

Sexual orientation, gender role, and body image are nearly secured as youth transition to adult roles.

Youth in this stage understand the consequences of their actions and behaviors, and they grapple with the complexities of identity, values, and ethical principles.

- ☐ Completion of the process of physical maturation.
- ☐ Many youth achieve the ability to understand abstract concepts and become more aware of their limitations and how their past will affect their future.
- ☐ Youth move to more adult relationships with their parents.

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<sup>1</sup> Adapted from: The Report of the National Commission on Adolescent Sexual Health

It is important to note that there is no such thing as an “average adolescent”. Individual adolescents vary widely in the pace of their development. Adolescent development is affected by parents, family members, other adults, school, and peer groups.

### Adolescent Sexual Health

Sexual health includes sexual development and reproductive health, as well as the ability to develop and maintain meaningful interpersonal relationships; appreciate one’s own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways **consistent with one’s own values**<sup>2</sup>.

Adolescent sexuality emerges from culture, ethnicity, gender, sexual orientation, class, and physical and emotional capacity. Adults can help foster and encourage safer adolescent sexual health by:

- ☐ providing accurate information and education about sexuality
- ☐ fostering responsible decision-making skills
- ☐ offering young people support and guidance to explore and affirm their own values
- ☐ modeling healthy sexual attitudes and behaviors.

### Patterns of Adolescent Sexual Experience

“Recognizing the diversity of sexual experiences may provide opportunities for more effective interventions for adolescents who have engaged in penile-vaginal intercourse.”<sup>3</sup>

“Young People are different; their sexuality is often thought out. Adults often times have disconnections about how we think about young people and their sexuality. We often define young people as ‘**sexually active**’ or ‘**not sexually active**’. We have to break traditional ways of thinking about youth. We need to start thinking out of the box!”<sup>1</sup>

The following are patterns of experiences that young people can be identified with.

- 1.Delayers:** Delayers have never engaged in sexual intercourse and may report a less than 50 percent likelihood of their first sexual intercourse occurring in the next year.
- 2.Anticipators:** Anticipators have never engaged in sexual intercourse and may report a 50 percent or greater likelihood of their first sexual intercourse occurring in the next year.

<sup>1</sup> Adapted from: The Report of the National Commission on Adolescent Sexual Health

<sup>2</sup> Definition from: The Report of the National Commission on Adolescent Sexual Health

<sup>3</sup> Adolescent Heterosexual Experience: A New Typology. K. Miller, L. Clark, D. Wendell, M. Levin, P. Gray-Ray, C. Velez, M. Webber. Journal of Adolescent Health 1997; 20:179-186

- 3.One-Timers:** One-timers have initiated sexual intercourse but have engaged in only one sexual act.
- 4.Steadies:** Steadies have initiated sexual intercourse, and often times report one sexual partner and had engaged in more than one sexual act with that partner.
- 5.Multiples:** Multiples have initiated sexual intercourse with more than one sexual partner and have engaged in more than one sexual act.

### Youth and HIV

- According to CDC estimate, about 1 in 4 (26%) of all new HIV infections is among youth ages 13 to 24 years. (CDC Vital Signs [2012], HIV among Youth in the US).
- CDC estimates that young MSM, especially those of minority races and ethnicities, are at increased risk for HIV infection. In 2009, young MSM accounted for 27% of new HIV infections in the US and 69% of new HIV infections among persons aged 13-29. (CDC Fact Sheet [2011], HIV/AIDS among Youth).
- About 86% of young females got HIV through heterosexual sex and 13% from injection drug use (CDC Vital Signs [2012]), HIV among Youth in the US).
- About 87% of young males got HIV from male-to-male sex, 6% from heterosexual sex, 2% from injection drug use and about 5% from a combination of male-to-male sex and injection drug use. (CDC Vital Signs [2012], HIV among Youth in the US).
- About 60% of youth with HIV do not know they are infected. These youth unknowingly pass HIV to others.(CDC Vital Signs [2012], HIV among Youth in the US).
- Studies have found that an increased risk for HIV infection exists among homeless, lower income, and school drop-out youth.
  - Diaz T, Chu S, Buehler, J, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. American Journal of Preventive Medicine 1994; 10:217-222.
  - Office of the Surgeon General. The Surgeon General's call to action to promote sexual health and responsible sexual behavior, 2001 (<http://www.surgeon general.gov/library/sexualhealth/call.htm>).
  - National Network for Youth. Toolkit for Youth Workers: Fact Sheet. Runaway and Homeless Youth, 1998. Available from the National Network for Youth, 1319 F Street, Suite 401, Washington, DC 20004; (202)783-7949.
  - Simmons, M.J.; LaLota, M.; Problem Behaviors versus the Situational Adversity Approach: HIV Risk Behaviors of Homeless Youth in Fort Lauderdale. Florida Public Health Review, 2005; 2: 96-107.
- Nationwide, among currently sexually active young people (13 to 24 years), 39.8% percent reported not using condom during their last sexual intercourse (CDC Adolescent and School Health [2012], Sexual Risk Behavior: HIV, STD, and Teen Pregnancy Prevention).

## Reference

“Teen Sexual Health”; MEDLINEplus Health Information; Website: [www.nlm.nih.gov/medlineplus/teensexualhealth.html](http://www.nlm.nih.gov/medlineplus/teensexualhealth.html) (A service of the National Library of Medicine).

## H. Homeless Populations

HIV is a significant issue facing homeless populations. Numerous studies have shown that rates of HIV/AIDS infection are three to nine times higher (varying among geographic locations) among persons who are homeless or unstably housed compared with persons with adequate and stable housing. Immediate survival is often the main concern for people experiencing homelessness. HIV prevention or even treatment may be seen as secondary to accessing food or shelter. Interventions with this population often require numerous linkages with additional services. About one-third of all homeless, single adults suffer from mental illness and impairments. Alcohol and injection drug use rates range from 20-80 percent among homeless adolescents and adults. Prostitution, victimization, and unprotected sexual activity are also factors that add to this population's increased risk for HIV infection. Furthermore, homeless persons often suffer from other co-infections (e.g., tuberculosis, hepatitis C) and a wide range of chronic health conditions (e.g., arthritis, heart disease, high blood pressure, seizure disorder). Such multiple conditions may complicate and accelerate the progression of HIV.

HIV counselors should be knowledgeable about local resources that assist the homeless and should be prepared to make referrals and linkages. Counselors should also be familiar with eligibility requirements and length of stay for shelters. **Remember, if basic human needs, particularly food and shelter, are not dealt with, the client may be less receptive to HIV-related services.** Additionally, referrals should be made for TB testing and other health and psychosocial services as appropriate.

**Due to the transitory nature of this population, anonymous testing should not be encouraged and rapid testing should be recommended, if available.** HIV counselors should also make extra efforts to obtain effective locating information for homeless clients. Determine what would be the most effective address to use on necessary paperwork. This could be the address of the local homeless shelter or a friend, relative or associate. Ask what phone numbers (shelter, friend, relative or associate) would be best to use if there was a need to contact them. This may prove invaluable in contacting the HIV-positive client testing confidentially who does not return for their test results at the scheduled time.

## References

FirstStep website – a tool for linking homeless clients with services.

(<http://www.cms.hhs.gov/apps/firststep/index/html>).

Florida Coalition for the Homeless; 1510 E. Colonial Drive, Suite 203W; Orlando, FL 32803.  
Telephone: 407-893-4410 or 888-917-3223. Website: [www.flacoalitionhomeless.com](http://www.flacoalitionhomeless.com).

2-1-1 Big Bend, Inc., Post Office Box 10950; Tallahassee, FL 32302-2950. Administrative  
telephone: 850-681-9131. Website: [www.211bigbend.org](http://www.211bigbend.org).

American Psychological Association. Inequality and HIV: The Role of Housing, Psychology  
& AIDS. Spring 2006, Issue 34.

Department of Health and Human Services (2003). HIV/AIDS, Severe Mental Illness and  
Homelessness (<http://grants1.nih.gov/grants/guide/pa-files/PA-04-024.html>).

## I. Incarcerated Populations

Given the high prevalence not only of HIV infection, but also of risk behaviors in incarcerated persons, HIV risk education is perhaps the most important part of HIV prevention counseling. Incarcerated populations often engage in high-risk sexual activities without protection because barrier methods (e.g., condoms) are not readily available. Sometimes these activities occur without consent, and persons are too embarrassed to discuss it. This presents an even greater challenge for HIV counselors in identifying HIV risks, particularly for male inmates who may not acknowledge same sex activities.

A study done in the United States (although no specific data exists for Florida) has demonstrated that inmates participate in a number of high-risk behaviors while incarcerated, including intravenous drug use (IDU), which is the risk behavior that contributes most to new HIV, HBV, and HCV infections. Additionally, it is highly probable that an inmate who is being treated for IDU has been exposed to unsafe sex (trading sex for drugs or money, for instance), meaning possible exposure not only to blood borne viruses like HBV and HCV, but also to HIV and other STDs.

It is critical that HIV counselors focus on the unsafe behaviors (e.g., anal sex without a condom, sharing needles, etc.), not the persons (man having sex with a man, injecting-drug user) with whom it occurred. By doing so, clients may feel more comfortable discussing their HIV risks and accepting testing, and they may be more receptive to allowing the counselor to assist them with devising a risk/harm reduction plan. Prevention counseling messages should include discussions of the benefits of early diagnosis and education regarding repeated testing, especially if potential exposure continues. Many clients behind bars may not participate in these risky behaviors on the “outside” and they go on with

their regular lives once released, possibly infecting their partners. **HIV testing and post-test counseling prior to release should be strongly encouraged with incarcerated populations.** Effective 7/1/02, Florida law requires all inmates in state prison (DOC facilities) to be tested for HIV at least 60 days prior to release.

HIV counselors must realize that for many persons who are incarcerated, access and opportunity for healthcare outside the prison walls are limited by multiple psychosocial and logistical obstacles. Incarceration is a unique opportunity for education and empowerment of these persons regarding health promotion, disease prevention, and treatment. However, incarceration does create real concerns about loss of confidentiality and fear of stigma that can prevent one from presenting for voluntary testing while in custody. HIV testing and education should be offered more than once during incarceration, especially to persons with the following conditions:

- ☐ Pregnancy, diagnosis of cervical neoplasm, and/or dysplasia in women
- ☐ Diagnosis of a prior or current sexually transmitted disease, diagnosis of hepatitis B or C, history of commercial sex work, history of sexual abuse, or history of drug use for men and women.

Denial, fear of illness, and concern about confidentiality are major deterrents for inmates. Concern about the cost of treatment by jails and correctional facilities may also contribute to delays in diagnosis. Every effort should be made with incarcerated clients and jail/prison staff to overcome these barriers. Given the short duration of time many inmates spend in county jails, rapid HIV testing should be used whenever possible.

## Reference

“HIV in Prisons and Jails, 2002”; U.S. Department of Justice; Bureau of Justice Statistics; website: <http://www.ojp.usdoj.gov/bjs/abstract/hivpj02.htm>.

## J. Vaccine Trial Participants

A vaccine is a medical product designed to stimulate your body's immune system in order to prevent or control an infection. An effective preventive vaccine trains your immune system to fight off a particular **microorganism** so that it can't establish a serious infection or make you sick. Preventive HIV vaccines are designed to protect HIV negative people from becoming infected or getting sick. Therapeutic HIV vaccines are designed to control HIV infection in people who are already HIV positive.

Although there is currently no vaccine to prevent HIV, researchers are developing and testing potential HIV vaccines. The goal is to develop a vaccine that can protect people

from HIV infection, or at least lessen the chance of getting HIV or AIDS should a person be exposed to the virus.

### How does a preventive vaccine work?

When your body encounters a microorganism, your immune system mounts an attack on the invader; after the microorganism is defeated, your immune system continues to “remember” how to quickly beat the invader should it try to infect you again. A vaccine is designed to resemble a real microorganism. The vaccine trains your immune system to recognize and attack the real microorganism should you ever encounter it. If you’ve received an effective vaccine, your immune system will “remember” how to quickly attack and defeat a particular microorganism for many years.

The experimental HIV vaccines currently being studied in **clinical trials** do not contain any “real” HIV, and therefore cannot cause HIV or AIDS. However, some HIV vaccines in trials could prompt your body to produce **antibodies** against HIV. These HIV antibodies could cause you to test “positive” on a standard HIV test, even if you don’t actually have HIV. New tests are being developed to distinguish between vaccinated and infected people. For more information, please visit <http://www.hvtn.org/sciencge/volunteerfaq.html> (click on “Will I test HIV-positive as a result of the vaccine?”).

### What are the different types of vaccine?

There are three main types of vaccines that are being studied for the prevention of HIV infection and AIDS:

- **Subunit vaccines**, also known as “component” or “protein” vaccines, contain only individual parts of HIV, rather than the whole virus. Instead of collecting these parts from the virus itself, the HIV subunits are made in the laboratory using **genetic engineering** techniques. These man-made subunits alone – without the rest of the virus – can prompt the body to produce an anti-HIV immune response, although that response may be too weak to actually protect against future HIV infection.
- **Recombinant vector vaccines** take advantage of non-HIV viruses that either don’t cause disease in humans or have been deliberately weakened so that they can’t cause disease. These weakened (attenuated) viruses are used as **vectors**, or carriers, to deliver copies of HIV **genes** into the cells of the body. Once inside cells, the body uses the instructions carried in the copies of HIV genes to produce HIV proteins. As with subunit vaccines, these HIV proteins can stimulate an anti-

HIV immune response. Most of the recombinant vector vaccines for HIV deliver several HIV genes (but not the complete set) and may therefore create a stronger immune response.

Some of the virus vectors being studied for HIV vaccines include ALVAC (a canarypox virus), MVA (a type of cowpox virus), VEE (a virus that normally infects horses), and adenovirus-5 (a human virus that doesn't usually cause serious disease).

- **DNA vaccines** also introduce HIV genes into the body. Unlike recombinant vector vaccines, DNA vaccines do not rely on a virus vector. Instead, "naked" DNA containing HIV genes is injected directly into the body. Cells take up this DNA and use it to produce HIV proteins. As with subunit and recombinant vector vaccines, the HIV proteins trigger the body to produce an immune response against HIV.

Again, none of these vaccines contain real HIV or anything else that could cause HIV infection or AIDS.

### **What is a prime-boost vaccination strategy?**

A single type of HIV vaccine may be used alone, or it may be used in combination with another type of HIV vaccine. One approach to combined HIV vaccination is called the prime-boost strategy. In this approach, administration of one type of HIV vaccine (such as a DNA vaccine) is followed by later administration of a second type of HIV vaccine (such as a recombinant vector vaccine). The goal of this approach is to stimulate different parts of the immune system and enhance the body's overall immune response to HIV.

### **Reference**

For more information on HIV vaccines, contact your doctor or an AIDSinfo Health Information Specialist at 1-800-488-0440, or visit the AIDSinfo website at [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov).

## **K. Occupational and Non-occupational Exposure to HIV**

### **Occupational Exposure to HIV**

Healthcare personnel who have contact with blood or other potentially infectious materials (OPIM) may have occupational exposure to HIV or other blood borne pathogens, primarily hepatitis B and hepatitis C. Infection control precautions should be followed at all times. The risk for getting HIV after a needle stick or an injury with a sharp instrument is about 1 in 300 or 0.3 percent. The risk is higher with one or more of the following factors present:

- An exposure to blood from a terminally-ill AIDS patient
- An exposure caused by a needle which was used in a blood vessel

- ☐ An exposure caused by a visibly bloody device
- ☐ A deep puncture.

Occupational exposure to the mucous membranes from a bloody splash is lower than a needle stick, less than 1 in 1,000 or 0.1 percent. Risk of HIV-infection after exposure via the skin is considered to be even less.

All healthcare personnel should be familiar with their facility's exposure control plan as well as infection control precautions (routine use of barriers, e.g., gloves and/or goggles when anticipating contact with blood or body fluids, washing hands or other skin surfaces immediately after contact with blood or body fluids, and careful handling and disposal of sharp instruments during and after use).

There are standard guidelines for the management of healthcare personnel exposures to HIV and recommendations for post-exposure prophylaxis (PEP) from the CDC (Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis; June 29, 2001. These guidelines may be accessed through the CDC's web site: [www.cdc.gov](http://www.cdc.gov)). These guidelines outline the considerations in determining whether or not PEP is indicated and which PEP medicines should be used. As written in the summary page of the June 29, 2001 guidelines, "Occupational exposures should be considered urgent medical concerns to ensure timely post-exposure management and administration of HBIG, hepatitis B vaccine, and/or HIV PEP." If PEP is indicated, it is best to start treatment as soon as possible after the exposure, hopefully within the first hour or two. Treatment is generally indicated for 28 days and the risk of HIV infection (from the single occupational exposure) is reduced by about 81 percent. The treatment generally involves multiple drugs and, as with any drug, there can be side effects. Clinicians may call the National Clinicians' PEpline at 1-888-HIV-4911, 24 hours a day, 7 days a week for consultation about PEP.

Healthcare personnel with an occupational exposure to HIV should receive the same pre- test counseling as other clients. Care should be taken to carefully explain the window period and risk reduction methods. Explanation about the possible test results should specifically include that if the baseline test, done on the exposure date, were to come back positive, it means the employee was previously infected with HIV prior to the current occupational exposure. If the baseline test is negative, then the employee should be retested according to his/her facility's exposure control plan protocol, generally at 6 weeks, 3 months, and 6 months. While the employee is in the window period, he/she should be strongly counseled about risk reduction methods so as to not infect their partner(s), in the event they would seroconvert from the occupational exposure.

In Florida, workers involved in a documented significant exposure who consent to testing but who object to name reporting may be tested using unique numerical identifiers rather

than their names. Should a person test HIV positive, use of the unique numerical identifiers will ensure that he/she is not reported by the laboratory.

## Non-occupational Exposure to HIV

Non-occupational PEP (nPEP) is taken when an individual is potentially exposed to HIV outside the workplace, for example, during episodes of unprotected sex or needle-sharing/injection drug use. Non-occupational exposure is any direct mucosal, percutaneous or intravenous contact with potentially infectious body fluids (not including perinatal situations). Patients presenting for nPEP should be evaluated as soon as possible so treatment, if indicated, can be initiated within recommended timeframes. To be most effective, evidence suggests a 72-hour timeframe for the initiation of nPEP following possible HIV exposure. nPEP initiation should be initiated as soon as possible following the exposure.

## References

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis (June 29, 2001).

National HIV/AIDS Clinicians' Consultation Center, University of California, San Francisco at San Francisco General Hospital, Frequently Asked Questions about Post-Exposure Prophylaxis...from the PEpline (August 2005).

## L. Testing In Nontraditional Settings

Counseling, testing and linkage (CTL) services provided in community-based and outreach settings (e.g., bars, parks, etc.) promote HIV testing among persons who are at increased risk and who may not otherwise access services in a clinical setting. The use of alternative testing technology, e.g., OraSure, also helps in promoting CTL services to clients because it is less invasive (no sticking with needles involved). It also offers providers portability, less complex sample collection and processing, and reduced biohazard risks. Providers offering CTL services in outreach settings should develop and implement written quality assurance protocols and procedures specifically for the provision of services. **Due to the transitory nature of many outreach clients, anonymous testing should not be encouraged.**

Outreach efforts for HIV rapid testing, via mobile units, has helped increase knowledge of HIV status among many groups. Rapid HIV tests can be used to reach groups in which HIV infection is often underdiagnosed. Community-based organizations (CBO) and county health departments are able to identify and provide rapid testing to local populations with 1) a high prevalence of HIV; 2) an overall high risk for HIV infection; and 3) a lesser likelihood of accessing traditional HIV counseling, testing and linkage services. CBOs will ensure that HIV-infected persons are successfully linked with HIV medical care and psychosocial services. Often, mobile units are able to increase knowledge of HIV serostatus among high-risk racial and ethnic minorities, in addition to increasing and assuring access to treatment and care services. Much higher proportions of those tested with rapid tests will receive their HIV test result. Sites that offer quality counseling services and rapid testing often have 100 percent return rates for test results.

Ensuring clients' privacy and confidentiality during CTL is essential, but could present unique challenges in some nontraditional settings. Confidentiality can more easily be breached in settings where clients and providers can be seen or heard by others. Some suggested strategies for maintaining privacy and confidentiality in nontraditional settings include:

- ☐ Use a separated area in a mobile van. The van should not have "HIV" or "AIDS" posted on it.
- ☐ Use rooms with locking doors. Rooms should not have "HIV" or "AIDS" posted outside.
- ☐ Mark a specific room with a "do not disturb" or "occupied" sign.
- ☐ In parks and similar locations, seek areas with as much privacy as possible.
- ☐ Provide counseling and testing services in the client's home or other secure setting.
- ☐ Have the clients return to the same setting where they received pre-test counseling to receive their test results.

## **Informed Consent**

Staff members providing CTL services should be sensitive to barriers that can interfere with obtaining true informed consent. These barriers may include alcohol and/or drug use, mental illness, and peer pressure in venues where persons congregate or socialize. When such barriers exist, some suggested strategies for obtaining informed consent in nontraditional settings include:

- ☐ Schedule an appointment to test at a later date/time.
- ☐ If contact information is available, follow up at a later time with the client.
- ☐ Read the informed consent form to the client.
- ☐ Use verbal prompts to ensure the client understands information in the informed consent form.

## **Counseling**

The quality of HIV prevention counseling should not be compromised because services are being provided in a nontraditional setting. In fact, it is more important to provide good prevention counseling because clients accessing services in a nontraditional setting may be at increased risk. Stressing the importance of receiving test results is vital with outreach clients because you are going to them to provide services. They are not coming to you. Clients in nontraditional settings may be less motivated to obtain results. They will need stronger encouragement to do so. Specifying a date and time for these clients to return to the same location is crucial to ensuring they learn their HIV status. This is particularly important for clients testing anonymously in outreach settings. The following strategies have proven to be useful in helping clients in nontraditional settings receive test results:

- ☐ Provide incentives (such as food certificates, hygiene kits, etc.).

- ☐ Return to the testing site on a regularly scheduled basis.
- ☐ Ensure that incarcerated and homeless persons will be at the same location when results return. If not, find out where they will be or give them your work phone number to inform you of their whereabouts.
- ☐ Use rapid HIV testing.

## **Testing**

The decision to offer HIV testing in nontraditional settings should be based on several factors, including availability of resources and feasibility of providing test results and follow-up. In some cases, linkage to other providers is appropriate. The selection of a specific HIV test technology should be based on logistical issues (e.g., field conditions related to collection, transport, and storage of specimens; worker safety, and the likelihood that clients will receive HIV test results). Providers must understand the extent to which field conditions can affect specimens (e.g., extreme temperatures or time lapse from collection to processing). Test specimens should be collected, stored, and transported according to manufacturer instructions.

## **Post-Test Counseling and Linkages**

Quality should also never be compromised when conducting post-test counseling with clients in nontraditional settings. This includes good HIV prevention counseling and the provision of linkages and referrals, particularly with clients testing positive. Some testing agencies (CHDs and CBOs) will contact HIV-positive outreach clients (testing confidentially) prior to their return to the specified location. This gives counselors the opportunity to provide positive results at clients' homes, test sites (office or clinic), or other private settings. Linkages and referrals can be made more effectively, and it also gives counselors more control over the situation in the event of erratic behavior by clients.

Staff should be trained to implement and manage linkages and referrals. Providers should establish appropriate collaborative relationships for linkages and referrals. Arranging for PS staff members (DIS) or case managers to be available to clients at the time test results are provided might help promote linkages to services.

## **Record Keeping**

Providers should develop written protocols for record keeping that address transport of client records to and from outreach venues. Protocols must conform to state laws. Publicly-funded test sites must also adhere to the Department of Health Information Security Policy, Model Protocols for HIV Counseling and Testing in Healthcare and Non- Healthcare Settings, HIV Counseling and Testing Forms Instruction Guide, Technical Assistance Guidelines 345-9-13: Provision of HIV Counseling, Testing, and Linkage Services, and other local policies.

## Staff Safety during Outreach

Providing services in outreach settings might compromise staff safety. Therefore, appropriate training and precautions guidelines should be developed. The following are some examples of these precautions:

- ☐ Identify community gatekeepers and develop an effective working relationship with them.
- ☐ Learn street terminology specific to targeted populations and geographic areas.
- ☐ Coordinate outreach activities with other agencies/staff that have experience working in that area.
- ☐ Inform office/clinic of where you will be and when you are expected to return.
- ☐ Work in teams whenever possible.
- ☐ Have cell phones available if your agency can afford them.
- ☐ Be constantly vigilant and monitor the situation for any signs of impending danger. Have contingency plans for worst case scenarios and share with fellow counselors. Leave any situation immediately if you feel unsafe or threatened.
- ☐ Avoid controversy and debate with clients and program participants.
- ☐ Be aware of weather conditions and be prepared for natural occurrences.
- ☐ At the first sign of weapons of any kind, immediately leave the area, go to a safe place and notify the supervisor of the situation. Have a sense for escape routes should trouble ensue.
- ☐ Wear picture ID, displayed prominently, at all times.
- ☐ Do not change attire to try to blend into the neighborhood.
- ☐ Do not wear expensive clothes, jewelry or shoes.
- ☐ In the event of law enforcement intervention at the outreach scene, counselors should not impede, obstruct or hinder such intervention in any way.
- ☐ Whenever possible, counselors should contact law enforcement officials prior to commencing outreach so law officers are aware of their presence and functions.
- ☐ Report any threat to safety to supervisor. An incident report may need to be completed according to agency policy.
- ☐ Monitor and communicate with each other and with similar programs regarding locations that present significant safety threats.

## Reference

“HIV CTR Services in Nontraditional Settings”; Revised Guidelines for HIV Counseling, Testing, and Referral; Morbidity and Mortality Report; November 9, 2001/50(RR19); 1-58. Website: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>.



# ***CHAPTER 5***

## ***HIV Risk Assessment***

## HIV RISK ASSESSMENT

Assessing a client's risk for HIV infection is an essential component of the counseling and testing process. The risk assessment involves asking the client a series of questions to determine past behavior that may have put him/her at risk for HIV infection. A risk assessment during a counseling and testing session should include questions about HIV testing, sexual behavior, prior and current sexually transmitted infections, and drug use. Since many of the questions may be of a personal and sensitive nature, it is important to inform and assure the client about the confidential nature of the risk assessment and the HIV testing process.

A risk assessment is designed to give the client and counselor a clearer picture of the client's risk behaviors that place them at risk for HIV. It also gives the client information to use when considering an HIV test. During the process of conducting an HIV risk assessment, the client may also bring up other needs or concerns which warrant some type of crisis intervention and/or linkage to services. Issues of rape, drug abuse and domestic violence are just a few of the concerns that may arise. It is important to remember that these issues may need to be addressed before a client is willing to discuss HIV testing. Questions during the risk assessment should be asked in a professional, culturally-sensitive and nonjudgmental manner. They should be concise and may be asked as open questions.

The Department of Health Form 1628 is the principal document for collecting information for a client accessing HIV testing. Revisions in the form have changed the manner in which some information may be gathered. Although open ended questions are the best way to solicit information, some questions may warrant simple yes and no answers.

Examples of questions that might be asked when doing a risk assessment are:

“Why do you think you should be tested?”

“What do you know about the HIV antibody test?”

“When was the last time you had sex?”

“What different people have you had sex with in the past three months? “Ever?” “How often do you use condoms when you have sex?”

“When was the last time you shot up drugs and shared the needle and/or syringe?”

“When was the last time you used any drug?”

The client may have behaviors indicative of risks for HIV. The client's self-perception of these risky behaviors is important. The client may realize they have done things to put them at risk of infection and not be concerned. There may be risk behaviors that are denied. A client may have no risk of infection but perceive they are at risk. He/she may even have a completely accurate self-perception of his/her risk.

The counselor can assist the client in better understanding HIV risk. If the client's self-perception of risk is accurate, he/she may need to be tested. If there is an unrealistic perception of his/her risk, the counselor should discuss with him/her the inaccuracies in that perception.

For instance, if the client has done something to put themselves at risk, he/she should be asked what they know about HIV infection and methods of transmission. The counselor can help the client to fill in the gaps in his/her knowledge. If the client has done things to put themselves at risk and he/she does not care, the counselor should still provide simple and specific information to the client. Although the client may not listen or care about what the counselor is saying, the counselor must remember the importance of the pre-test counseling session and provide the risk reduction or risk elimination messages. It is not the counselor's job to make the client change undesirable behavior into something acceptable. Only an individual can choose to change his/her own behavior. The counselor can only assist and guide the client in the direction toward a positive behavior change. If a written questionnaire is used to assess the client's risk, the counselor should review the written assessment and address these risks during the one-on-one counseling session.

While not listed on the risk assessment form, it may be necessary to assess the impact the test result may have on the client should he/she choose to be tested. Questions that may be asked are:

"What are your expectations about the test results?"

"How would you feel if your test was positive?"

"What changes would you make if your test was positive?"

"How would you feel if your test was negative?" "Who would you plan to tell about your test result?"

Finally, by completing an HIV risk assessment and discussing the impact of a potential test, a client is verbalizing their own risk factors. While seemingly a simple process, verbalizing one's risk factors compels the client to take a certain level of ownership for their behaviors. This is a vital step in the process of developing a personalized prevention plan. Since sexual contact and drug use are the most common modes of transmission for HIV, it is important to understand why and how these behaviors place individuals at risk.

### **Significance to Self (Personalizing Risk)**

The counselor should help the client personalize his/her risk. It is human nature to downplay the consequences of risky behavior. For example, an individual may begin smoking cigarettes to look older or more "sophisticated" while thinking that lung cancer is something that happens only to others. A teen might speed in their car feeling invincible

because he/she cannot personalize the risk. They may visualize others getting into an accident, but not themselves.

A client may not be able to visualize or personalize their risk for HIV infection, although they may be putting themselves at risk every day by shooting drugs and sharing needles or by having sex under the influence of alcohol or other non-injecting drugs. The counselor's role is to help the client personalize his/her risk and "own up to it" by asking how THE CLIENT thinks this risk may relate to his/her behavior. The client must realize the significance of this risk in order to take the first steps toward changing behavior.

Here is a sample list of questions that can be asked to assess risk behaviors that have occurred at any time in the client's life (ever), and within the past three months:

- ☐ When was the last time you...
  1. Had vaginal or anal sex with a male?
  2. Had vaginal or anal sex with a female?
  3. Had vaginal or anal sex with a transgendered person?

Consider the fact that someone could have had sex with a person of the same sex when they were younger, but not since. If you were to ask that person if they were gay, you might get a "no" response. Also, the counselor should not assume that if someone tells you that he/she is gay that he/she has never had sex with someone of the opposite sex.

Generally, if you are counseling a male, ask "when was the last time you had sex with a woman" first and then ask "when was the last time you had sex with a man." If you are counseling a female, you would ask the same questions but in reverse. We live in a predominantly heterosexual society; therefore some heterosexuals may become upset if you ask them the same sex question first. In their minds, they may think that you believe they are gay. Since most gay men, lesbians, bisexual and transgender clients are aware that we live in a predominately heterosexual society, they are less likely to be offended by asking the questions in the above explained order, thereby implying heterosexual activity.

- ☐ When was the last time you...
  1. Injected non-prescription drugs?
  2. Had sex while using non-injection drugs or alcohol?

If you ask a client if they inject drugs, he/she may not currently be injecting drugs. It may be a behavior they no longer engage in. They may have in the past, but not now. You would then get an incorrect answer to that question. However, by asking the question in the manner illustrated above, you facilitate

the proper response. Also remember that it is the act of needle sharing that increases risk of infection, and some clients may inject medications while sharing needles.

☐ When was the last time you had sexual relations with ...

1. An injection drug user?
2. A known MSM?
3. A person with hemophilia/coagulation disorder?
4. A transfusion or transplant recipient?
5. Someone who exchanged sex for drugs, money, or other items?
6. A person with unknown HIV status?
7. An anonymous partner?
8. A person with HIV or AIDS?

By asking the question "when was the last time you..." you are encouraging an honest answer and an answer that may open other avenues for discussion.

☐ When was the last time you ...

1. Received clotting factor for hemophilia/coagulation disorder?
2. Received a transfusion of blood/blood components (non-clotting factor)?
3. Received a transplant of tissues, organs or artificial insemination?
4. Worked in a health care or clinical lab setting?

Although the revised Department of Health 1628 no longer records the number of sex and/or needle sharing partners in the past 12 months, this remains an important question in the discussion of risk reduction and behavior modification.

☐ How many ...

1. Sex partners have you had in the last 12 months?
2. Needle-sharing partners have you had in the last 12 months?

To encourage honesty with numbers it is best to ask these questions in this manner. Many clients may hold the belief that it is wrong to have multiple partners, so if the counselor asks the question in such a manner as to only receive a yes or no answer, the client may decide to lie. By asking in this open-ended fashion, the counselor will be facilitating trust.

☐ When was the last time you had unprotected sex?

This is the easiest way to ask this difficult question. The reason this is important is to assess the window period and exposure.

## **Alternatives to Risky Sex**

Since almost all sexual contact between two individuals involves some degree of risk, there is no such thing as “safe sex.” There is, however, safer sex. It is important to provide options for those who have engaged in risky sexual behavior in the distant and not so distant past. By providing alternatives to risky behavior, the client can choose from a “smorgasbord” of behaviors that are not likely to transmit HIV and other sexually transmitted diseases. These are sometimes referred to as Outercourse.

In addition to using latex barriers (including condoms and dental dams) for vaginal/anal/oral intercourse (as referred to in a previous chapter), here are some Outercourse options to provide to a client who is not ready to choose abstinence as an option for risk reduction behavior:

- ☐ Masturbation - this is manual stimulation of the genitals.
- ☐ Mutual masturbation - when two sex partners stimulate each other's genitals to orgasm, with no exchange of body fluids
- ☐ Showering together without sexual contact
- ☐ Massage - often, when an individual thinks he/she wants sexual contact a massage from a partner gives him/her a good feeling and satisfies the need for touch.
- ☐ French kissing - HIV is not spread by saliva, but the presence of blood would increase the risk.
- ☐ Frottage - this is the rubbing of two bodies together, either clothed or unclothed, without penetration and without genitals touching each other.
- ☐ Petting or fondling
- ☐ Watching stimulating videos, phone sex and cybersex without physical contact.

## **Alternatives to Risky Drug Use**

Although using illegal drugs is never a behavior to encourage in an individual, occasionally the counselor will need to understand that the client may be unable to change this behavior. If the counselor recognizes that the client plans to continue to shoot drugs, the counselor should encourage the client to not share needles with anyone as the best way to prevent infection.

It is the sharing of needles and paraphernalia that is the behavioral risk for HIV, not the drug use itself. Although the counselor should discuss linking the client to a drug treatment program, ceasing the sharing of needles is a good first step in HIV prevention.

When it is evident the client has no plans to stop sharing needles and/or drug injection devices, the counselor should demonstrate how needles can be decontaminated with bleach and water. HIV can be easily killed once it is outside the body. Destroying HIV within the needle and syringe can be accomplished by drawing full strength bleach into the needle and

syringe three times and shaking the bleach each time. If bleach is not available to clean the needle and syringe, any drinkable liquid drawn several times into it would be better than doing nothing. Then, water needs to be drawn into it three times to rinse the bleach out. (Bleach can be deadly if it is injected full-strength into the veins.) The client should also be advised not to share any other drug paraphernalia.

Being inebriated with alcohol or using other mind-altering drugs can lead to HIV risk as inhibitions disappear. If a client is not drunk or high during the time sexual contact is about to occur, he/she is more likely to think clearly and employ risk reduction or elimination measures. The counselor should encourage the client to be clear-headed when thinking about having any type of sexual contact.

## **Prevention Counseling**

Counselors should help clients develop a personal risk reduction plan to decrease their risk of contracting HIV. The plan should be realistic, yet challenging and should address the specific behaviors identified by clients during the risk assessment phase of the counseling and testing session and should incorporate the client's previous attempts, perceived personal barriers, and perceived personal benefits to reducing HIV risk. Discuss how clients will put the plan into operation, using specific and concrete steps. It is also important to establish a "back-up" plan. The counselor should work with the client to ensure that the plan is personalized and acceptable. Questions should be solicited to reinforce the client's commitment to a risk-reduction plan. Some programs create a "contract" with the client to emphasize the importance of the risk-reduction plan. Suggested open-ended questions to use when assisting clients to develop a personal risk reduction plan:

- ☐ What one thing can you do to reduce your risk right now?
- ☐ What can you do that will work for you?
- ☐ What could you do differently?
- ☐ How would your sexual practices and/or drug related practices have to change for you to stay safe?
- ☐ Now that you have identified some steps you can take, how can you go about making this happen?
- ☐ What can you do to make these steps easier?
- ☐ What would help support you in taking these steps?
- ☐ When do you think you will have the opportunity to first try this behavior or discussion?
- ☐ How realistic is this plan for you?
- ☐ What will be the most difficult part of this for you?
- ☐ What might be most difficult about making this change?
- ☐ Who can help you?
- ☐ How will things be better for you?

- ☐ How will your life be easier or safer if you change?
- ☐ How would your drug practices have to change to stay safe?

Suggested statements supporting and reinforcing the client:

- ☐ You have really done something good for yourself in putting this plan into place.
- ☐ You have taken very positive steps today to help meet some important goals.

### **Referral, Linkage, Support and PrEP**

Providing HIV counseling and testing services and identifying HIV infection is one part of the duties and responsibilities of the HIV counselor. Counselors must also ensure that people living with HIV receive information on community resources, have referrals for needed services and are actually linked to health and psychosocial services as needed within the community.

Pre-exposure Prophylaxis (PrEP) is a once-daily pill, taken orally, in conjunction with prevention strategies to reduce the risk of acquiring HIV infection. Currently, the only medication approved by the FDA for PrEP is tenofovir disoproxil fumarate (TDF) 300 mg co-formulated with emtricitabine (FTC) 200 mg, known as Truvada®. PrEP is recommended as a prevention option for individuals at higher risk of acquiring HIV infection, including adult men who have sex with men (MSM), high-risk adult heterosexually active men and women, adult injection drug users (IDU), and adults whose partners are known to be HIV infected.

A series of clinical trials have demonstrated the effectiveness of PrEP. The guidelines are based on strong evidence from PrEP clinical trials that were conducted in high-risk populations. These studies did not find any significant safety concerns with daily use of PrEP. The new federal guidelines for health care providers recommend that PrEP be considered for people who are HIV negative and at substantial risk for HIV infection.

For sexual transmission, this includes anyone who is in an ongoing relationship with an HIV-positive partner. It also includes anyone who:

- 1) is not in a mutually monogamous relationship with a partner who recently tested HIV-negative, and
- 2) is a gay or bisexual man who has had anal sex (insertive or receptive) without a condom or been diagnosed with a sexually transmitted infection (STI) in the past 6 months; or a heterosexual man or woman who does not regularly use condoms during sex with partners of unknown HIV status who are at substantial risk of HIV infection (e.g., people who inject drugs or have bisexual male partners).

For people who inject drugs, this includes those who have injected illicit drugs in the past 6 months and who have shared injection equipment or have been in drug treatment for injection drug use in the past 6 months.

Health care providers should also discuss PrEP with heterosexual couples in which one partner is HIV positive and the other is HIV negative (HIV-discordant couples) as one of several options to protect the partner who is HIV negative, including the use of PrEP during conception and pregnancy.

Counselors should identify appropriate peer and community support for HIV risk reduction, as well as provide referral for professional services directed at addressing specific issues identified by each client during the risk assessment. Suggested questions could be:

- ☐ We've talked about lots of issues today. Which of the things we've discussed would you like more help with?
- ☐ Would you like to talk with an individual counselor about .... (issues that have

- been raised)? Would you be interested in a support group?
- ☐ Is there a particular kind of support or service that you would be willing to consider?

### **Targeted Versus Routinely Recommended HIV Counseling, Testing and Linkage**

Providers in all settings (traditional and nontraditional) should ideally recommend counseling, testing and linkage (CTL) to all clients on a routine basis to ensure that every client who could benefit from CTL receives these services. However, resources might be insufficient to permit this practice. Therefore, guidelines have been developed to ensure that as many persons as possible who are at “high risk” for HIV and do not know their status have access to testing, prevention counseling, and linkages. (An extensive discussion of this is found in the Morbidity and Mortality Weekly Report’s “Revised Guidelines for HIV Counseling, Testing and Referral”, website: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>.)

Decisions regarding whether to recommend routine or targeted services are based on the behavioral and clinical HIV risk of the client population in the setting, the level of HIV prevalence of the setting, and the behavioral and clinical HIV risk of individual clients.

These factors should not be used to determine recommendations for CTL in circumstances in which treatment potential exists (i.e., perinatal transmission and acute occupational or non-occupational exposure).

In low prevalence setting (e.g., <1 percent), CTL should be targeted to clients based on risk screening. In high-risk settings (e.g., 1 percent or greater), all clients should be routinely risk assessed and be recommended for HIV counseling and testing. (See Module II, Section E, p. 33 for a resource on risk screening in low prevalence settings. Pages 34-35 of that section contain algorithms for offering testing in low and high prevalence settings.)



# ***CHAPTER 6***

## **HIV Pre-Test Counseling, Informed Consent and Post-Test Counseling**

## HIV PRE-TEST COUNSELING

HIV pre-test counseling is a continuation of the risk assessment that addresses accomplishments and challenges of previous risk reduction attempts. Clients should be encouraged to commit to a single, explicit step to reduce their risk. Clients are more likely to comply with a concise, self-developed risk reduction plan based on risk information that they have been made aware of through the counseling session.

### Things to Remember About HIV Pre-Test Counseling

- Florida's Prevention cooperative agreement with CDC requires that 90% percent of clients who test positive for HIV receive their test results and 90% of clients who test positive for HIV are linked to care. Pre-test counseling should be provided in a manner that encourages clients to return for their results. Any barriers related to clients receiving their results should be eliminated or reduced. **The primary goal of pre-test counseling is threefold:**
  1. To discuss the need for testing.
  2. To elicit behavior changes that will further reduce risk.
  3. To make the client aware of available services.
- Healthcare settings conducting HIV tests are not required to provide pre-test counseling. Any non-healthcare setting such as county health department HIV testing programs, community-based organizations, outreach settings, and mobile vans must provide HIV pre-test counseling prior to testing for HIV.
- Informed consent shall be obtained prior to testing for HIV in non-health care settings except in the limited situations outlined in Section 381.004 (2)(h), F.S. Informed consent shall include an explanation that the information identifying the test subject and the results of the test are confidential and protected against further disclosure to the extent provided by law. Information shall also be included on the fact that persons who test positive will be reported to the local county health department, that anonymous testing is available and the locations of anonymous testing sites. Informed consent is not required in healthcare settings. The client need only be informed that the test will take place and that they have the option to opt out. Informed consent to perform a test for HIV in a non-health care setting need not be in writing, if there is documentation in the medical record (1628 file) that the test has been explained and consent has been obtained.
- Florida law requires that a healthcare provider who attends a pregnant woman for conditions relating to her pregnancy test for HIV and other STDs at the initial visit and counsel her on the availability of treatment if she tests positive.

- All pregnant women must be advised of, the need to know their status, the risk to unborn children, and treatment regimens that are available to reduce the risk of perinatal transmission. If a pregnant woman tests HIV negative at the initial visit, test for HIV and other STDs again at 28-32 weeks' gestation. The counselor is to **complete the DH 3161 "Statement of Objection" when a pregnant woman declines HIV testing.**
- Counselors should also be sensitive to the issue of domestic violence and the effect it may have on the client's ability to negotiate safer sexual practices, or his/her willingness to notify partners of possible exposure. Counselors should be aware of local shelters and make referrals and linkages as appropriate. The Florida Domestic Violence Hotline (1-800-500-1119) provides information and referrals in English, Spanish, and Haitian Creole.
- Information from the pre-test counseling session should be documented in clients' records and on the DH 1628 Laboratory Request Form, as specified in the HIV Counseling/Testing Forms Instruction Guide.
- The pre- and post-test counseling sessions, and the informed consent process, are slightly different when rapid testing is done. Please refer to the rapid testing counseling guidelines at the end of this chapter.

The following model should be used during the pre-test counseling session:

1. Discuss indications for testing (medical indication and/or information obtained from the risk assessment).
2. Establish and/or improve the client's self-perception of risk.
3. Identify and support behavior changes the client has already attempted.
4. Explore situations which increase the likelihood of high-risk behaviors.
5. Discuss options for eliminating and/or reducing risk.
6. Negotiate a realistic and incremental plan for eliminating and/or reducing risk. Have client commit to at least one concrete, achievable behavior change step. Writing down the agreed upon goal may be useful.
7. Discuss the possible need for retesting as it relates to the client's being inside or outside the "window period". Most infected persons will develop detectable HIV antibodies within three (3) months of exposure. In very rare exceptions, it may take up to six (6) months for these antibodies to develop.
8. Discuss the importance of notifying sex and/or needle-sharing partners if test results are positive, the availability of Partner Services (PS) through the CHD STD Program, and how confidentiality is protected if PS is accepted. Anonymous clients should be informed if they elect to utilize PS through the CHD STD Program, there is a possibility they may be named as a contact to an infected partner. Therefore, their anonymity may be jeopardized.

9. Discuss the potential social, medical, and economic impact of a positive test result.
10. Provide information on support services that are available during the waiting period for test results (e.g., hotlines, pre-test counselor's name and work telephone number, CHD number, etc.).
11. Emphasize the necessity of returning for test results. Give a return appointment date at least two weeks from the date of the pre-test counseling session (If results are taking longer than this, please contact the Bureau of HIV/AIDS, Early Intervention Section.) Give the client the "Return Appointment" card located on page two of the DH 1628, lower right corner, and emphasize the importance of bringing it and a picture ID to the post-test counseling appointment. Provide literature and condoms as appropriate.
12. Inform the client that the counselor who conducts the pre-test counseling session may not be the same for post-test counseling. All efforts should be made to ensure that the same counselor is available. Due to clinic flow and other related issues, this may not be possible.

## **Informed Consent**

Healthcare Settings - No person shall perform an HIV test without first notifying the person to be tested that the test is planned and that he or she has the right to refuse. Limited exceptions can be found in section 381.004(2)(h), Florida Statutes, and in Florida Administrative Code Rule 64D-2.004(1). Notification may be oral or in writing. Refusal to test shall be documented in the medical record.

Non-health care Settings - No person shall perform an HIV test without first obtaining the informed consent of the test subject or his or her legal representative. Informed consent to perform a test for HIV need not be in writing if there is documentation in the medical record that the test has been explained and consent has been obtained. Exceptions can be found in Florida Administrative Code rule 64D-2.004(3)(a)(b)(c). The limited exceptions to obtaining informed consent can be found in section 381.004(2)(h), Florida Statutes, and in Florida Administrative Code rule 64D-2.004(1).

When obtaining informed consent from the client, the counselor should explain the following:

- ☐ Meaning of "confidential" and the client's right to confidential treatment of all information relating to his/her appointment and testing. The client should also be aware that Florida law provides penalties for breaches of confidentiality.

- ☐ The HIV antibody test determines if an individual is infected with the virus that causes AIDS, the reliability of the results, and the meaning of positive, negative, and indeterminate results.
- ☐ Procedures that will be used to collect the specimen for HIV testing are traditional blood draw, oral swab, and finger stick.
- ☐ HIV antibody testing is voluntary, and consent to be tested can be withdrawn at any time prior to testing.

Explain to clients who test confidentially that a positive HIV test result is reported to the local CHD in a way similar to the way other diseases are reported. HIV infection reporting should not be presented in such a way as to deter confidential testing. HIV infection reporting allows Department staff to offer follow-up activities to those who test positive, including post-test counseling for those who do not return for test results, linkages to medical and psychosocial services, and voluntary PS. Confidential testing can more readily facilitate access into medical care for positive clients and can assist medical providers in offering more integrated care for other medical conditions that positive clients may have. Referrals to medical and psychosocial services and PS should also be offered to those who test positive anonymously.

**Information must be given on the availability of anonymous testing as an option.** If anonymous testing is not available at a test site and clients want to be tested anonymously, a list of local anonymous test sites should be given to these clients. A list of anonymous sites can be found at:

<http://esetappsdo2.doh.state.fl.us/DconAids/ClinicSearch.aspx>

## SUMMARY - The Pre-Test

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IF THE CLIENT IS THOUGHT TO BE AT RISK FOR HIV INFECTION AND CHOOSES TO BE TESTED, COUNSELORS SHOULD:

1. **Establish rapport by introducing** him/herself to the client (particularly if he/she did not do the risk assessment).
2. Explain the **confidential** nature of this session and types of testing available.
3. Describe the test and the **testing process** (EIA and Western blot).
4. Describe what a **negative, positive & indeterminate** test means and describe the role of the "**window period**" for detection of antibodies.
5. Ask the client what impact a negative or positive test result would have on his/her behavior and what behavior changes he/she would make in each instance.
6. Review HIV infection reporting.
7. Assess for domestic violence.
8. Make an appointment for the client to return for his/her test results and stress the importance of keeping the appointment.
9. Inform the client of the importance of **reducing or eliminating his/her risk** of exposure to HIV during the time he/she is waiting for the test results.
10. Discuss appropriate risk reduction and elimination measures (**personalize his/her risk**).
11. Provide written **information and condoms**, if appropriate.
12. **Document** client risk information on the DH 1628 HIV Lab Request Form and verify the client's signature on the consent form.
13. Make appropriate referrals and linkages.
14. Answer all questions the client may have.

# HIV NEGATIVE AND INDETERMINATE POST-TEST SESSION

## Things to Remember about HIV Negative Post-Test Counseling

- ☐ Prior to the client entering the counseling room, the counselor should review risks identified during pre-test counseling and the date of the last time the client had any type of sexual encounter. This information should be used to guide the counselor in determining whether the client was inside the “window period” at the time of this test, and the appropriate time for retesting.
- ☐ The client may be very nervous about receiving test results. The counselor should not waste time discussing the weather, the waiting time, etc. He/she should genuinely greet the client warmly, verify his/her identity, remind him/her of the confidential nature of the visit, then **GIVE THE RESULTS IMMEDIATELY**.
- ☐ Reassessing the client for risk information may reveal additional risk factors not previously mentioned during the pre-test counseling. Many clients who test negative will disclose more risk information on post-test because he/she may feel a sense of relief knowing their negative status.
- ☐ PrEP should be discussed and recommended in all situations where the client has self-identified as high risk or the results of the pre-test counseling indicate high risk activity. Pre-exposure Prophylaxis (PrEP) is a once-daily pill, taken orally, in conjunction with prevention strategies to reduce the risk of acquiring HIV infection. Currently, the only medication approved by the FDA for PrEP is tenofovir disoproxil fumarate (TDF) 300 mg co-formulated with emtricitabine (FTC) 200 mg, known as Truvada®. PrEP is recommended as a prevention option for individuals at higher risk of acquiring HIV infection, including adult men who have sex with men (MSM), high-risk adult heterosexually active men and women, adult injection drug users (IDU), and adults whose partners are known to be HIV infected. When taken every day, PrEP provides a high level of protection against HIV, and is even more effective when combined with condoms and other prevention tools. In several studies of PrEP, the risk of getting HIV infection was much lower—up to 92% lower—for those who took the medication consistently than for those who did not take the medication.

High-risk negative clients should be linked to a medical provider for PrEP assessment and initiation.

## Things to Remember About HIV Indeterminate Post-Test Counseling

- ☐ The client may be in the process of seroconverting to positive.
- ☐ Clients testing indeterminate may be as upset as those testing positive, due to the uncertainty.
- ☐ Clients with initial indeterminate results should be retested.
- ☐ Clients with repeatedly indeterminate results should be counseled regarding other testing options, such as antigen testing. Recent exposure to HIV should be ruled out first.

The following protocol should be used when giving HIV-negative or indeterminate results:

1. Introduction and purpose of the session. Verify the client's identity.
2. Explain confidentiality and the security of confidential information.
3. Provide results **IMMEDIATELY in a simple, understandable manner**.
4. Explain the meaning of the results, including the “window period”.
5. Wait for the client's reaction to the results, and assess his/her emotional stability.

6. Discuss the need for retesting if the client is found to be inside the window period or if result is indeterminate with a blood draw sent to the state lab for 4<sup>th</sup> generation HIV testing. Most infected persons will develop detectable HIV antibodies within three (3) months of exposure; however, on rare occasions, it may take up to six (6) months for these antibodies to develop. Persons with initial indeterminate results should be retested at the time of post-test counseling. Persons with continued indeterminate results after one month are highly unlikely to be infected and should be counseled as though they are not HIV-infected, unless recent exposure is suspected, per the CDC Revised Counseling, Testing, and Referral Guidelines.

However, clients who request additional evaluation may be referred or linked to antigen testing. A specific return date should be given for all retesting.

7. Reevaluate client's risk.
8. Discuss/review risk reduction plan. If client has ongoing risk, convey concern and urgency about the risk to the client and refer/link appropriately.
9. Provide additional referrals and linkages, literature, and condoms as needed. Referrals and linkages should be documented on the DH 1628c HIV Post-Test Documentation Form (yellow copy) and mailed to the Bureau of HIV/AIDS, as specified in the HIV Counseling/Testing Forms Instruction Guide.

## SUMMARY - NEGATIVE/INDETERMINATE POST-TEST

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### In The Seronegative/Indeterminate Post-Test Counseling Session, the Counselor Should:

1. **Introduce** him/herself to the client. Verify the client's identity.
2. Remind the client of the confidential nature of the session.
3. Give the result immediately.
4. Explain the **meaning** of the test result.
5. Discuss the possible need for **re-testing** due to the window period.
6. Discuss with the client a **plan of action**.
7. Re-assess for domestic violence.
8. Discuss **risk reduction or elimination** modalities which are appropriate to the client (help him/her to personalize his/her risk).
9. Advise the client **not to donate blood or other body fluids and tissues** if he/she is still at risk of HIV infection.
10. Address any **questions** raised by the client.
11. Give **written information and condoms** when appropriate.
12. Provide **support information** and phone numbers as appropriate.
13. Give an **appointment** time if re-testing is necessary.
14. Complete the "**HIV Post-Test Documentation Form**" and send to State Health Office.

**REMEMBER:** Discuss how the client has been doing with previously agreed upon changes in behavior relating to sexual options, drug options, and universal precautions.

### REINFORCE:

- ☐ Knowledge: Awareness and information about HIV risk
- ☐ Self-efficacy: Responsibility for actions, decisions, and self control
- ☐ Significance to self/personalize risk: Relate to client/client aware of the risk

- ☐ Cost/Benefit analysis: Change may have a cost to the client. (Is it worth it to the client?)
- ☐ Capacity building: Support needed for client to change behavior
- ☐ Provisional tries: It may takes several times for behavior change
- ☐ Behavior change: client moves back and forth from awareness to change and back.

**Additional Information:**

Discuss donations of blood, blood products, semen, tissues or organs.

Provide condoms, literature.

Make referrals/linkages.

Schedule re-testing appointment date, if needed.

Answer any questions.

## HIV POSITIVE POST-TEST SESSION

Counselors should be mentally and emotionally prepared to give a client a positive test result. The counselor's thoughts and emotions should not take precedence over the client's. If a counselor is not ready (mentally and emotionally) to give a positive result, another more experienced counselor should give the results. Although giving a positive result for the first time may be very difficult, counselors usually get better at it with time.

### Things to Remember about HIV Positive Post-Test Counseling

- ☐ Prior to the client entering the counseling room, the counselor should review risks identified during pre-test counseling, have referral and linkage lists readily available, and be prepared for the whole gamut of responses (from no response at all to suicidal).
- ☐ The client may be very nervous about receiving test results. Do not waste time discussing the weather, etc. Greet him/her warmly, verify the client's identity and **give the results immediately**.
- ☐ If the counselor feels the client is suicidal (by saying or doing anything to indicate that he/she will do harm to himself/herself), initiate the appropriate protocol that is set up at your place of business (e.g., calling 911 outside of the counseling room) and do not leave the client alone. If police are called, they should not be told the reason the client is suicidal, only that the client said/indicated that he/she would do harm to himself/herself.

The following protocol should be used when giving HIV-positive results:

1. Introduction and purpose of the session. Confirm the client's identity.
2. Explain confidentiality and the security of confidential information.
3. Provide results clearly and simply. Results should be given immediately.
4. Explain the meaning of the results.
5. Ensure the client understands the results.
6. Assess how client is coping with results.
7. Acknowledge the challenges of dealing with a positive result and provide appropriate support.
8. Assess who the client would like to tell about her/his positive results and who can provide support in dealing with HIV.
9. Discuss situations in which the client may want to consider protecting her/his confidentiality, e.g., with landlords, realtors, insurance agents, or employers.
10. Discuss positive living. If the client is not ready for this discussion, provide her/him with literature that is appropriate for the client's reading level.
11. Explain the purpose and advantages of receiving early intervention services, and how treatment and support may prolong and improve the quality of his/her life.

12. Assess client's willingness to access support, and link him/her to all available services to which the client would be most receptive. Linkages may include, but not be limited to, OB/GYN, family planning, HIV clinic, tuberculosis clinic, substance abuse treatment, medical case management, STD and hepatitis screening, and domestic violence counseling.
13. Address the need for health care providers to know client's HIV status.
14. Inform all pregnant women who test positive for HIV of the benefits of anti-HIV therapy during pregnancy, where she can go to obtain the medications, and that breast feeding can transmit HIV infection to her newborn infant. In addition, all pregnant women who test positive for HIV antibodies will be linked to the local Healthy Start Coalition and medical case management. HIV testing should be encouraged for the baby's father and any other of the woman's children, as appropriate.
15. Reevaluate client's risk.
16. Discuss/review risk reduction plan, including risk of additional infection exposure and transmission to others. The discussion may include abstinence and/or safer sex practices, not sharing needles, proper cleaning of injection materials, condom use/demonstrations, etc. The client should also be informed of the penalties for criminal transmission of HIV (s. 384.34, Florida Statutes), reasons not to donate blood, blood products, semen, tissues and organs, and the importance of protecting his/her immune system.
17. Discuss client's past and present sex and/or needle sharing partners who may have been exposed to HIV. All HIV-positive clients must be asked if they have, or have had, a spouse at any time within the ten-year period prior to the diagnosis of HIV infection. If so, the client should be informed of the importance of notifying the spouse or former spouse(s) of the potential exposure to HIV. The client must be informed of the availability of confidential PS through the CHD STD program for spouse or former spouse(s) and any sex or needle-sharing partners.
18. Provide additional referrals and linkages, literature, and condoms as needed. Referrals and linkages should be documented on the DH 1628c HIV Post-Test Documentation Form (yellow copy) and mailed to the Bureau of HIV/AIDS, as specified in the Department of Health HIV Counseling/Testing Forms Instruction Guide.
19. Discuss with the client his/her immediate plans after leaving the test site.
20. If the client fails to keep his/her follow-up appointment, the counselor should notify the CHD STD Program within 24 hours. A Disease Intervention Specialist will immediately initiate an investigation.

## SUMMARY - POSITIVE POST-TEST

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### In The Seropositive Post-Test Counseling Session, the Counselor Should:

1. **Introduce** him/herself to the client and confirm the client's identity.
2. Remind the client of the confidential nature of the session.
3. Give the client the positive test result **immediately**, and pause for the client's reaction.
4. Explain the **meaning** of the test result.
5. Discuss with the client a **plan of action**.
6. Link the client to early intervention medical evaluation and services and local STD program for Partner Services (PS).
7. Discuss **risk reduction or elimination** appropriate to the client's situation and lifestyle (remind him/her about personalizing his/her risk and the fact he/she could infect others).
8. Re-assess for domestic violence.
9. Advise the client **not to donate blood or any other body fluids or tissues**.
10. Discuss HIV **infection reporting and partner elicitation**.
11. Address any **questions** raised by the client.
12. Give **written information and condoms** as appropriate.
13. Provide phone numbers and information on all available support services. Assess the patient's emotional and mental state before allowing him/her to leave.
14. Follow up on the patient with a phone call; exercising caution to ensure his/her confidentiality is not compromised.

**REINFORCE:**

- ☐ Knowledge: Awareness and information about HIV risk
- ☐ Self-efficacy: Responsibility for actions, self control, and decision-making
- ☐ Significance to self/personalize risk: Relate to client/client aware of the risk
- ☐ Cost/Benefit analysis: Change may have a cost to the client (Is it worth it to the client?)
- ☐ Capacity building: Support needed for client to change behavior
- ☐ Provisional tries may take several times to effect behavior change.
- ☐ Behavior change in the client can move back and forth from awareness to change and back.

**Additional Information:**

Provide condoms, literature.

Make appropriate linkages.

Schedule re-testing appointment date, if needed.

Answer any questions.

Document information on "HIV Post-Test Documentation Form" and send to the State Health Office.

# Florida Rapid HIV Testing Counseling Guidelines

The following document is an addendum to the current HIV counseling model set forth by the Florida Department of Health. The primary objective of this document is to provide guidance to counselors on how to incorporate the rapid testing process into their current counseling strategies.

## **Section I: Introduction and Risk Assessment**

### **I. Describe the roles and responsibilities of the client and counselor and set objectives with the client as to what will be accomplished in the session.**

- A. To establish initial rapport with the client, the counselor will need to convey positive regard, genuine concern and an empathetic response toward the client. This client-centered connection will help build trust and will set the tone for the rest of the session.

### **II. Counselor and client should engage in discussing client's personal risk behaviors.**

- A. The counselor is attempting to focus the client's attention on their behavior and the corresponding risk of acquiring or transmitting HIV. The counselor's approach to this component of the session will shift based on the client's particular issues in addressing HIV risk.
- B. The counselor should have an open and inquisitive approach to this portion of the session. This approach will stimulate the client's curiosity and encourage them to self-reflect and examine their own behaviors. The exploration of the risk behavior should be specific.
- C. The counselor should explore any previous changes initiated by the client to reduce their HIV risk(s). This provides the counselor with an essential opportunity to offer support and reinforce the client's previous efforts.
- D. If the client has not initiated any changes, the counselor should provide the client with prevention options available and assist the client in making their decision on what would be a realistic prevention plan.

### **III. Summarize and characterize the client's risk behavior by helping the client to identify their previous pattern of risk behavior. Attempt to enlighten the client to specific vulnerabilities and affecting triggers of their risk behavior.**

- A. This component of the session should allow the client to gain an understanding of the factors that influence the behaviors that put them at risk for HIV infection. In an easy to understand manner, the counselor summarizes the inter-related factors that may be influencing the client's risk behavior. This summary provides the client with an organized perspective of his/her own narrative. The counselor's approach to this should be culturally sensitive, empathetic and non-judgmental. This approach should help the client understand and realize his or her own personal risk behavior(s).

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## Section II: The Rapid HIV Test

- I. **Following a client-centered risk assessment, the counselor will determine which individuals should be offered a rapid HIV test.**
  - A. This component of the counseling process deviates from the traditional model and focuses on the counseling perspective as it relates to rapid HIV testing. When offering a rapid HIV test, it is strongly recommended that sites offer the test in a confidential manner, and are equipped to obtain the specimens (blood or oral) needed for confirmatory testing. Sites that are able to collect these specimens ensure that clients identified as reactive (preliminary positive) are not lost through referral to a secondary facility for additional testing. In addition, the information provided to the counselor in a confidential manner can aid in locating the client if their confirmatory result is positive and they do not return for these results. Locating these clients is essential to providing them with linkages to medical and support services.
  - B. The counselor should describe the process, and place emphasis on the benefits and drawbacks of the rapid test in a manner that the client can understand. The benefits may include: the quick test results if client is negative; the testing sample requires only a fingerstick of blood; and the test is considered as accurate as a traditional test done in a lab. Drawbacks may include: the impact of a quick test result if the client is positive; that a reactive result will require additional testing for confirmation; the results from the additional test will not be available for approximately two weeks; and some linkages to services such as PrEP may be initiated immediately.
  - C. The rapid test may be administered once the client has accepted the rapid test and the counselor obtains informed consent.

Preparing the client to take a rapid HIV test	
Protocol	Content
Assess if client wants an HIV test	"Based upon our discussion, how would you feel about taking an HIV test today?"
Explain to client about confidential and anonymous testing	<i>Follow traditional protocol. Inform the client that the rapid test is a testing option once the client has expressed their desire for a confidential test.</i>
Inform client of available tests and briefly describe the testing procedures	<i>Assume client asks about rapid test</i>
Review the rapid test process	
1. Same day test results	"This test will give you your results in "X" minutes (this depends on the test being used."
2. Conclusive if negative	"This test is as accurate as the HIV screening tests that are performed in laboratories. If the test does not detect HIV antibodies, a single line will appear. Generally, it takes no more than three months for antibodies to develop after a person has been infected."

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3. Preliminary if positive	“If the test does detect HIV antibodies in your blood, two lines will appear.
4. Confirmatory test required if reactive	“If the rapid test detects HIV antibodies, we will need to take a second sample, preferably a blood draw, from you and confirm this result through our lab. You can expect these results approximately two weeks from now.”
Benefits and drawbacks of the rapid test	<p>“Based upon what I have told you about the rapid test and the testing process, what benefits would you see in taking this test?”</p> <p>“What drawbacks would you see in taking this test?”</p>
Assess client’s ability to cope with test results on the same day	<p>“How would you feel about taking an HIV test and getting the results today?”</p> <p>“How prepared do you feel to receive these results today?”</p> <p>“What types of support do you have when you leave here today (e.g., someone to talk to about your concerns over being tested)?”</p> <p>“What do you think you might do if the test is reactive today? What do you plan to do once you leave here?”</p> <p>“If your result today is reactive, would you be willing to give a specimen for a confirmatory test?” If client answers no, counselor should re-emphasize the importance of linkages to services.</p>
Client chooses rapid test	<i>Informed consent is obtained, the test is administered, and the client goes to waiting room/or receives further counseling</i>

### **Section III: The Negative Result**

- I. **Counselor provides clear and accurate results with an emphasis on client risk reduction in order to remain negative.**
  - A. The counselor should provide the initial test result in simple terms, avoiding technical jargon. The counselor should allow the client to experience their pleasure at probably not being infected while emphasizing the need for behavior change in order for the client to remain negative. The counselor should cautiously explore feelings and beliefs the client has about their negative test result, particularly in the context of the risk behavior the client has described thus far in the session. The counselor should be alert to the possibility that the client may experience some disinhibition (i.e., feel more inclined to engage in risky behavior) in response to the results. The client may believe their negative test result is an indication that he/she has, thus far, made the “right choices” while participating in risky activities, or in picking partners. It is often helpful for the counselor to underscore the fact that the negative test result does not

## Florida Rapid HIV Testing Counseling Guidelines

indicate that the client's sex/needle sharing partner(s) are not infected. There is a slight possibility that a recent risk behavior (especially in the last month) may have resulted in the client becoming infected without the infection being indicated in this test result. However, both counselor and client should be reminded that the current result represents all other, sometimes years', previous risk behavior. Counselors must be very careful with their "retest message." If there is not a significant risk in the previous 3 months, then no additional test is indicated unless the client has a later exposure to HIV. If there is a very recent and significant risk exposure, there is a small chance that the client could have been infected by that exposure. If this exposure exists, the client is encouraged to provide a blood sample for 4<sup>th</sup> generation testing at the state lab. The client may be seroconverting and in an acute state.

- B. The counselor should avoid technical discussions of this information and recommend, when necessary, a specific time for possible retest linked to a specific previous date of exposure. In summary, a brief explanation of the possible need for retesting is sometimes, with some clients, important, but this should not be over-emphasized. Too much attention to retesting takes away attention away from the risk reduction process and often inaccurately diminishes the meaning of the HIV negative result.

Negative Rapid Test Result	
Protocol	Content
Welcome client back	"Welcome back. Come on in and have a seat."
Provide results immediately, clearly and simply	"Let's look at your test result, and then we'll talk about how to best understand the result."  "Your test result is negative, which means no HIV antibodies were found at this time."
Review meaning of the results	"This means that unless you've had a recent exposure, you are probably not infected with HIV."  "How does it feel to hear that it is very likely that you are not infected with HIV?"  "How do you plan on staying HIV negative?" <i>Go to Section V</i>

### **Section IV: The Reactive (Positive) Result**

- I. **The counselor provides clear and accurate results with an emphasis on client risk reduction in order to protect them from other STDs and to prevent transmission if they are infected. The counselor also should re-emphasize the need for confirmatory testing. Every effort should be made to ensure an additional specimen is collected from the client before the end of the session.**
- A. The priority for this component of the session is to ensure that the client correctly understands the test result. The counselor should provide the initial test result in simple terms, avoiding technical jargon. The counselor should choose language that reflects the likelihood that the client is actually infected with HIV. In choosing phrases to convey the meaning of the initial test result, the counselor should consider the client's reported risk behavior. The counselor should be clear with the client that the information provided by the client in the beginning of the session, particularly the risk

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assessment, may help influence the client and counselor's understanding of the results. This may provoke the client to offer additional details concerning risks that he/she was reluctant to address initially. The counselor should remind the client that this result is preliminary and review the process of confirmatory testing. The counselor must emphasize the need for confirmatory testing, as well as the importance of the client returning for additional results, and identify sources of support while awaiting test results. The counselor should acknowledge that receiving this initial result could be disconcerting, elicit feedback from the client as to how he/she is feeling about the result, and provide appropriate support. The counselor must also provide the client with information on Test and Treat, explaining that he/she may be linked to a clinician who may further determine if the client is ready to initiate a 30 day supply of drug immediately.

- B. When faced with a reactive result, the counselor should further emphasize the client's need for a risk reduction plan. If a client is HIV positive, they can still contract other STD's, which can place greater exertion on their immune system and accelerate the onset of AIDS-related illnesses. In addition, the client can possibly become re-infected with a different strain of HIV (through unprotected sex or needle sharing with an infected person), which can also accelerate the onset of AIDS-related illnesses. It should also be pointed out to the client that by adopting a risk reduction plan, they are not only protecting themselves from other STDs but can protect their partners from contracting HIV. It is advisable to notify clients about the possible legal ramifications of having unprotected sex with a partner who is unaware of the client's positive HIV status. Clients should think about how they might notify their partners, both past and present. *Note: There is a small chance that, although the client's rapid test results were reactive; their confirmatory test may be negative.*

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Reactive (Positive) Rapid Test Result	
Protocol	Content
Welcome client back	"Welcome back. Come on in and have a seat."
Provide their results immediately, clearly and simply	<p>"The initial test result is reactive, indicating that you are likely infected with HIV."</p> <p><b>Note: A positive result can only be determined by a confirmatory test. This is why the result is "reactive".</b></p>
Review the meaning of a preliminary result	"Remember that the initial result must be confirmed before concluding whether or not you have HIV infection."
Include the client's risk assessment into the understanding of the initial result and the availability of Test and Treat.	"Given what we've discussed about your potential exposures to HIV, this result is very likely to be correct." We can link you to a clinician who can access you for a 30 day supply of drug as part of the Test and Treat program.
Assess how client is coping with their result	"How are you feeling about this initial result?"
Acknowledge the challenges of dealing with an initial positive result and provide appropriate support	<p>"It can be difficult dealing with the possibility that you're infected with HIV. How are you doing?"</p> <p>"Who can be supportive of you in dealing with this?"</p>
Re-emphasize the importance of confirmatory testing	"It is important, regardless of your previous risk exposures, to take the confirmatory test. Results from this second test will let us know if you are truly infected with HIV. If you are infected then we can help place you into medical and support services."
Indicate to client the importance of protecting themselves and their partners. (This would be a good opportunity for the counselor to mention PS).	<p>"As we discussed earlier, this is a screening test and your result needs to be confirmed with an additional test. While you are awaiting your confirmatory results, it is very important to prevent getting or, potentially, spreading any type of infection."</p> <p>"How are you planning do this?"</p>
Contract with the client utilizing a negotiated return date strategy for the client to retrieve the additional test results	<p>"Two weeks from today is (date/time). How does that fit into your schedule for getting your confirmatory results? How committed are you to returning at that time?"</p> <p>"What could prevent you from returning at that time? Here is my business card; please call me if you run into any problems."</p> <p>"Let me check that I know how to reach you so we can be sure you receive the confirmatory test result (review address/phone number)."</p> <p><i>Go to Section V</i></p>

## Florida Rapid HIV Testing Counseling Guidelines

- II. **The counselor and client should work together to develop a specific, concrete and incremental plan designed to assist the client in reducing their risk for acquiring or transmitting HIV.**
  - A. The risk reduction plan is a fundamental component of the prevention counseling session regardless of whether the client received a positive or negative test result. The counselor should assist the client in identifying a behavior that corresponds to their risk and that he/she is invested in changing. It is essential that the plan match the client's skills and abilities with their motivation to change a specific behavior. The counselor should challenge the client to go beyond what he/she has previously attempted in terms of risk reduction. The plan must be specific in that it describes the who, what, where, when and how of the risk reduction process. It must be concrete in that it details the successive actions required of the client to implement and complete the risk reduction plan. Finally, it must be incremental in that it is directed at a single aspect of the risk behavior or one particular factor/issue that contributes to that risk behavior. The counselor should avoid supporting risk reduction plans that involve unreasonable or radical changes in the client's life.

### **Section V: The Invalid Result**

- II. **There are times when a rapid HIV test result may be invalid. An invalid result can be determined if:**
  - 1. A control line does not appear
  - 2. The lines are outside of acceptable areas
  - 3. No lines form after 20 minutes

If a result is invalid, the counselor should give the client the option to either retest with another rapid test, or take a traditional test. ***NOTE: The counselor should not attempt to interpret an invalid result.***

### **Section VI: Close of rapid HIV test counseling session.**

- I. **At the close of the rapid HIV test counseling session, the counselor should make one final attempt to re-enforce the behavior changes discussed with the client.**
  - A. The counselor should encourage the client to continue pursuing positive behavior changes addressed in the session and come back for further testing if needed. In addition, counselors should address prevention tools such as condoms and any other items covered in traditional post-test counseling. This is also the time to ensure that the client knows their return date if they have given a specimen for a confirmatory test, and for the client and counselor to address any barriers facing client in returning for their second appointment.



# **MODULE II**

## ***HIV/AIDS 501***

### ***Section B***

#### ***Referrals/Linkages***

## REFERRALS/LINKAGES TO MEDICAL CARE AND SERVICES

Referral services should be offered to all clients of HIV test sites who are in need of medical, preventive, and other supportive services, particularly clients who are high-risk HIV negative and HIV positive. Accessing appropriate services increases the likelihood that high-risk HIV negative and HIV-positive clients will maintain good health, have greater longevity and quality of life, and reduce the risk of transmission. Reasonable efforts should also be made to link high-risk, HIV-negative clients to appropriate services including PrEP, to reduce the likelihood of these clients acquiring HIV.

Linkages differ from referrals because linkage requires prevention counselors to provide direct assistance to make possible the completion of referrals. This may mean the provider places a phone call to a referral agency to set an appointment for the client, or to ensure that the client followed through with an appointment. It may also mean that a form for a specific agency is given to the client. The form includes the address, phone number, and, possibly, contact person of the linkage agency. The agency can send a copy of the form back to the provider with documentation that services were/are provided to the client. In any event, clients should be provided with assistance in accessing and completing linkages, and completion of linkages should be verified.

Typical linkage needs of HIV-positive clients and other clients of HIV test sites may include but are not limited to the following:

- ☐ Partner Services (PS) for sex and/or needle-sharing partners
  - ☐ Case management
  - ☐ Medical evaluation, care, and treatment
  - ☐ Pregnancy issues (e.g., prenatal care, anti-HIV drug intervention therapy)
- Additional referrals for positives and high-risk clients may include:
- ☐ Domestic violence counseling
  - ☐ Referral for HIV antibody retest, if the client requests it
  - ☐ Reproductive health services
  - ☐ Mental health services
  - ☐ Sexually transmitted disease screening and treatment
  - ☐ Prevention case management
  - ☐ Tuberculosis skin test
  - ☐ Substance abuse prevention and treatment programs
  - ☐ Screening and treatment for viral hepatitis.
  - ☐ PrEP, nPEP, and PEP

HIV test sites should maintain current lists or resource guides of local agencies and should be familiar with their services. Lists or resource guides should include the following:

- (1) Name and address of referral agency, website URL and e-mail
- (2) Range of services provided
- (3) Target population (s)
- (4) Geographical service area (s)
- (5) Contact names, phone and fax numbers and e-mail
- (6) Days and hours of operation
- (7) Cultural, linguistic, gender and age-appropriate competence
- (8) Cost for services
- (9) Eligibility requirements
- (10) Application process
- (11) Admission policies and procedures
- (12) Directions, transportation information, and accessibility to public transportation
- (13) Client satisfaction with services.

An important component of linking clients to care is for the staff that makes the referral to have detailed knowledge of the agency and the services they provide before recommending it to a client. Getting negative feedback on an agency after you have sent a client there may harm your connection with the client and the linkage may not have been in the client's best interest. The client should be told of things unique to that agency, such as: the time in the waiting room is usually several hours, the office is often cold or crowded, the paperwork they will be required to produce, etc.

HIV test sites should establish and maintain good working relationships with these agencies, and have a contact person at each agency. Having interagency collaborative agreements/arrangements with agencies can help facilitate linkages. Agencies should be responsive to clients' needs and service provision should be culturally, linguistically, developmentally, gender, and age-appropriate. Test sites should be aware of any barriers to clients' accessing services at agencies and should work with these agencies to reduce or eliminate barriers whenever possible. Capacity building should take place with new or developing agencies whenever possible to ensure the availability of various needed services.

## References

2-1-1 Big Bend, Inc., Post Office Box 10950; Tallahassee, FL 32302-2950. 850-681-9131.  
Website: [www.211bigbend.org](http://www.211bigbend.org). HIV/AIDS Resource Directory: <http://www.irissoft.com/aids/>



# ***CHAPTER 1***

## ***HIV/AIDS Patient Care***

## **HIV/AIDS PATIENT CARE PROGRAMS**

HIV/AIDS patient care activities within the HIV/AIDS Section are designed to provide and promote community-based care and support services to eligible persons living with HIV disease throughout Florida. A number of state and federally funded programs are available to people with HIV/AIDS. Most of these services are provided by private, not-for-profit, community-based AIDS service organizations and facilities. The Patient Care Program provides technical assistance to Department of Health staff, Ryan White Part B Consortia and Planning Body members, service providers, and the public in general, about the patient care programs. A summary of the primary HIV/AIDS patient care programs administered through the Florida Department of Health include but are not limited to the following:

### **The Ryan White Part B Program**

The Ryan White HIV/AIDS Treatment Extension Act of 2009 represents a major focus of the federal response to the need for direct patient care and support services for persons living with HIV and AIDS. The Ryan White Part B Program provides outpatient medical care, pharmaceuticals, dental services, mental health counseling, case management, and many other support services planned through the 14 federally funded regional HIV care consortia operating statewide and implemented locally by Ryan White Part B lead/fiscal agencies.

### **AIDS Insurance Continuation Program (AICP)**

The AICP, administered by Florida's Department of Health, HIV/AIDS Section, is funded by federal Ryan White Part B and State of Florida General Revenue funds. The AICP assists Ryan White Part B eligible Floridians diagnosed with AIDS or symptomatic HIV disease pay their private health insurance costs, allowing them to maintain their insurance coverage. Historically, the AICP provides \$5 in medical services for each dollar spent on insurance costs, thus benefiting the client who maintains their existing medical coverage and services, and the taxpayers.

### **AIDS Drug Assistance Program (ADAP)**

The AIDS Drug Assistance Program is the largest program funded primarily through Ryan White Title II and provides HIV/AIDS-related pharmaceuticals to low-income, under-insured, or uninsured persons in Florida. The ADAP, administered by Florida's Department of Health, HIV/AIDS Section, provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

## **County Health Department and Patient Care Network Programs**

In addition to the statewide Ryan White Part B program, there are two state general revenue funding sources allocated to the larger counties to provide HIV/AIDS patient care services. County health departments in 31 of Florida's counties have specific general revenue funds to operate HIV/AIDS patient care services and provide primary medical care and support services to improve the health of HIV/AIDS patients. In addition, patient care networks in five geographical areas of the state are also funded through general revenue as services legislatively mandated and defined by Rule.

## **Housing Opportunities for Persons with AIDS (HOPWA)**

Housing Opportunities for Persons with AIDS, known as HOPWA, is a federal Housing and Urban Development-funded program which provides temporary mortgage, rent, and utilities assistance to adversely affected individuals with HIV/AIDS. There are ten HOPWA programs statewide administered by the Department of Health.

Contact the local HIV/AIDS Program Coordinator in your area for COMPLETE information regarding the eligibility criteria, policies, procedures, manuals, and guidelines available relating to these HIV/AIDS patient care programs.



# ***CHAPTER 2***

## ***Partner Services***

## **PARTNER SERVICES (PS)**

### **History of HIV PS in Florida**

Since 1987, the Florida Department of Health, Sexually Transmitted Diseases and HIV/AIDS Sections have utilized Partner Services (PS) as a key component of Florida's comprehensive HIV prevention program. HIV PS is a public health activity with two major goals: 1) interrupt HIV transmission by providing services to partners so they can avoid infection or, if already infected, prevent transmission of HIV to others; and 2) assist partners in accessing counseling, testing, medical evaluation, treatment, and other prevention services.

PS is one of the core functions of the Department of Health, Bureau of STD Control and Prevention Section. STD field staff serves as the front line of defense against the spread of HIV and other sexually transmitted diseases (STDs). This is done through conducting activities aimed at identifying sex and/or needle sharing partners of someone with a disease communicable through sex or shared needles, informing them that they have been exposed to the disease, and offering counseling, testing, and treatment referrals and linkages.

All Disease Intervention Specialists (DIS) are required to successfully complete an intensive, four-day, CDC course, Introduction to STD Intervention (ISTDI). During the ISTDI course, DIS learn about the medical aspects of various STDs, the science of patient interviewing, the techniques of disease case management and field investigations, the methods of infection control, and how to address a variety of administrative concerns. Prior to attending the course, DIS must pass exams covering 10 modules on STD control, infectious disease characteristics and human anatomy, disease case management, gonorrhea, syphilis, HIV/AIDS, visual case analysis, infection control, and STD field investigation.

The term PS has evolved over the years to better reflect the range of services available to HIV-infected persons, their partners, and affected communities. In the 1930s, the process was called "contact tracing" and was widely advocated by U.S. Surgeon General, Thomas Paron, as a means to prevent and control the transmission of syphilis, a potentially fatal STD. It was called contact tracing because public health workers would, and still do, conduct analyses to determine which sex partners were most likely to be infected or at risk of developing infection and then make confidential efforts to locate them and provide treatment.

In fact, interviewing individuals with communicable diseases, ensuring they receive appropriate treatment, and, depending on the disease, notifying and referring household

and close contacts for testing and treatment are common disease prevention and control practices utilized in public health.

In the 1980s, contact tracing was expanded to include partners of persons infected with other STDs such as gonorrhea, and Chlamydia, as well as HIV, and became known as partner notification.

In 1998, the CDC revised its guidance on partner notification, including a shift in terminology. Currently, the term Partner Services more accurately reflects the range of services available to HIV-infected persons, their partners, and affected communities.

### **PS Benefits The Client, The Partner, and The Community**

HIV-infected persons participating in a PS session benefit from the counseling services provided by the DIS designed to assist them in modifying behaviors that place them at risk of future infections, decrease the likelihood of further transmission, as well as provide linkages to medical and social services. In addition, HIV-infected clients are able to have their partners informed of their exposure to HIV without revealing their own HIV status, thus offering peace of mind and fulfilling their ethical responsibility to their partners.

Sex and/or needle sharing partners of an HIV-infected client benefit from PS by being provided information about their actual risk of HIV infection. In many cases, actual risk is often misunderstood, or underestimated, and provides the boost for them to learn their own HIV status. A 2001 study of newly-infected heterosexual patients indicated that one in five did not know that their partner was HIV positive when they were infected, or that their partner had engaged in any high-risk behaviors. In addition, a survey of 132 partners of HIV-infected clients revealed that only 12 (9%) thought they might have been exposed to HIV before health department notification.

Often, persons believe they are in mutually monogamous relationships and are unaware that they may be at risk. For instance, one study of a group of Mexican men indicated that 89% reported their primary partner was unaware of their secondary partner, and one-third reported that their secondary partner did not know about the primary partner.

In one survey of Swedish men, researchers concluded that 10% of the most sexually active men accounted for 48% of all sexual contacts, suggesting that those persons with very few sexual partners are still likely to be exposed to people who have had sex with many partners. Both studies illustrated that persons may often place their partners who believe they are in a “mutually monogamous” relationship at risk for HIV infection.

Partners voluntarily accepting HIV testing can be provided this service “on the spot” through blood, oral fluid collection or in some cases rapid testing. Partner notification and

testing in the field allows the client to “process” the news in a less stressful environment. The client is able to express their fears and emotions privately rather than being placed in a clinic setting. Blood is the preferred testing method used by DIS because they can also screen partners simultaneously for syphilis. This is important because people at risk for HIV infection are also at risk for other STDs. Persons who test positive can benefit from earlier diagnosis and medical attention and increase the likelihood of improved prognosis and quality of life. DIS may also refer both positive and negative clients to prevention case management and other counseling and support services, provide prevention counseling and increase awareness of risk, and assist partners in adopting behaviors that reduce the likelihood of acquiring or transmitting infection in the future.

PS benefits the community at large by reducing the emotional and financial burden of disease, and identifying and treating previously undiagnosed HIV infections. PS decreases transmission of HIV within a community through individual behavior modification and reduces individual infectivity through the use of antiretroviral therapy. PS can also assist in identifying high morbidity areas and disease networks, enabling a more targeted approach to HIV prevention/early intervention activities at the community level.

### **Essential Concepts of PS**

The Centers for Disease Control and Prevention outline five essential concepts involved in PS (HHS, 1999):

1. PS is voluntary. Because PS relies on the willing participation of HIV-infected individuals and their partners, it can never be made mandatory or coercive. An atmosphere of trust can encourage clients to participate.
2. Confidentiality must be protected. Ensuring clients that their privacy will be strictly protected may overcome an obstacle to PS. DIS are trained in methods that never identify the original client by name, gender, physical description, race, age, type of exposure, dates of exposure, or location. In turn, the original patient is not informed of their partners' status. Strict adherence to Department of Health policies, procedures, as well as state and federal laws, is maintained by all DIS.
3. Client-centered communication is most effective. As HIV prevention counselors, you recognize the importance of utilizing client-centered communication. Client-centered communication is conducted in an interactive manner, focuses on the issues and realities faced by the client, and takes into account the client's unique circumstances.

4. PS is available to clients who test at both confidential and anonymous sites. A client who tests anonymously may seek help in notifying partners without giving his or her name. Any partners to be notified by a DIS are identified by name so the DIS can verify the person's identity. Clients testing anonymously who consent to PS and choose to maintain their anonymity are informed that a partner testing HIV positive may name them back. This would result in a DIS, not knowing that the client had tested previously positive, re-locating them and offering voluntary counseling, testing, and referral services at a later date. In turn, partners who are notified by DIS may choose to test confidentially or anonymously.
5. PS is ongoing. The first time a client learns of his or her HIV infection is not the only opportunity for PS. Case management agencies, HIV/AIDS clinics, substance abuse facilities, and other agencies that provide services to HIV-infected persons are encouraged to stress the importance of informing new partners of their HIV status. If protection is not used with new partners, these clients should be encouraged to tell their partners about testing options.

## **Referring Partners**

The Florida Department of Health, STD Prevention and Control Section uses three approaches for reaching sex and/or needle sharing partners of HIV-infected clients:

1. Health Department/DIS referral. The HIV-infected client requests assistance in confidentially notifying their partners and voluntarily provides names, descriptions, and addresses to the DIS so that the notification process can be carried out. This method is designed to protect the anonymity of patients. Their names are never revealed to sex and/or needle-sharing partners. The DIS takes complete responsibility for contacting the partner and notifying him or her of possible exposure to HIV, conducts HIV prevention counseling, provides field testing, or refers them for testing.
2. Client referral. The HIV-infected client chooses to inform their own partners directly of their risk of infection. The DIS coaches the client, often through role plays and a personalized discussion that takes into consideration both the needs of the client and their partners, how to sensitively inform sex and needle-sharing partners about their potential risk for infection. In Florida, DIS still follows up to ensure that partners have been notified. Follow ups may include phone calls or field visits to the original patient (OP) to ensure notification has taken place. If partners have not been notified, the DIS will discuss with the OP other means to notify all partners.

3. Contract referral. The HIV-infected client chooses to inform their partners within a negotiated time period. The DIS agrees to inform partners if the client is not able to meet the timeline. A plan of action is developed with the client for notification and referral of partners. If the client is unsuccessful, the DIS assumes the responsibility for partner notification. The DIS coaches the client and gathers full exposure, locating, and identifying information on the partner(s).

### **Interview Period**

The interview period for HIV, or the time period that partners are elicited for, is typically one year, although, DIS will often go as far back as the client indicates. The CDC recommends a one-year interview period because it offers the best chance for prevention, early intervention, and ability to locate partners. In order to comply with the Ryan White CARE Act Amendments of 1996 (Pub L. No. 104 – 146 [May 2, 1996], states receiving funds under part B must show a “good faith” effort to notify marriage partners of infected clients within the last 10 years (MMWR Nov. 2008 57(RR09); 1-63).

### **The Role of the HIV Prevention Counselor in PS**

The HIV prevention counselor plays an integral role in PS during the pre-test and post- test positive counseling sessions. Since PS depends upon the voluntary cooperation of the patient, one of the jobs of the HIV prevention counselor is to bring up the topic of partners, demonstrate to the client the benefits of PS, and encourage cooperation with county health department DIS. Counselors should inform clients that if they test positive a DIS may contact them to initiate PS before they return to the initial testing agency for results.

During the pre-test counseling session and prior to consenting to be tested for HIV, clients should be made aware that if they test positive for HIV, they will be asked about sex or needle-sharing partners or if they have been married at any time within the past 10 years. If so, they will be informed of the importance of notifying their current and/or previous spouse(s) as well as other partners of their potential exposure to HIV and offered the assistance of public health personnel in notifying partner(s).

The counselor can recommend that the client begin thinking about all of their sex and needle-sharing partners and ways they can be located. HIV prevention counselors can assist the client to begin thinking about partners and how they can be located by asking open-ended questions such as:

- ☐ How many sex and/or needle-sharing partner(s) have you had in the last year?
- ☐ Where is your partner today?
- ☐ Who knows you are being tested for HIV today?

- ☐ How does your partner feel about you coming in today?

During a post-test positive counseling session, the HIV prevention counselor should remind the HIV-infected client of their responsibility to assure that sex and/or needle-sharing partners are counseled about their exposure to HIV. The client should also be reminded of the benefits of PS to themselves and their partner(s). HIV-infected clients should be linked to the local STD control and prevention program and documentation of the linkage should occur on the post-test counseling form. It is important to note that PS should be provided in a timely manner. Early research results indicated that individuals infected with HIV can transmit the virus to someone else in just five days, underscoring the need for timely PS activities to quickly identify the partners of people newly infected with HIV.

## **CASE STUDIES IN PS**

The following case studies highlight the importance of PS as an effective HIV prevention strategy. They were adapted from a report by the Wisconsin Division of Public Health.

### **PS Initiated with Charlotte**

Charlotte is a 23-year-old single black female who sought treatment for a persistent sore throat at the local county health department. Upon examination, the physician diagnosed her with candidiasis, an illness typically associated with compromised immune function. Subsequently, Charlotte was risk assessed for HIV and offered voluntary testing. Charlotte pondered on what the results of the test would be. To her knowledge, she wasn't aware she was at risk for HIV. Thus, she had never been tested previously. Charlotte returned to the health department for her results and was informed that she indeed was infected with HIV. How could this be? She had used condoms with most of her past partners. After Charlotte was post-test counseled, she was introduced to a county health department DIS. The DIS contacted the local case management agency who would be able to link her with the additional services she might need, scheduled an appointment with the county health department HIV care clinic for initial viral load testing and CD4/CD8 counts, and referred her to a local support group.

Charlotte's fiancé tested HIV negative through his primary care physician. Charlotte believed she was infected during sexual intercourse with another man while on vacation two years previously. Charlotte reported using condoms with this partner and indicated no other risk behaviors. The DIS discussed common routes of HIV transmission and explained that transmission of HIV was unlikely during correct condom use. Because this was the first time Charlotte had been tested for HIV, the DIS discussed Charlotte's partners during the previous five years. Charlotte reported four other sex partners. Follow-up with these partners resulted in two males testing negative, one not located, and another, Tony, diagnosed with HIV infection several years ago.

Follow-up revealed that Tony was diagnosed with HIV infection prior to his involvement with Charlotte. He had been contacted by a DIS on several occasions following his initial diagnosis but refused to divulge names of his partners and insisted he had informed them of his HIV diagnosis.

PS was reinitiated and, after a long conversation, Tony acknowledged that he had not informed any of his sex partners of his infection. He expressed remorse and provided the DIS with as many names and locating information as he reported remembering. Tony revealed that he was initially unable to accept the fact that he was HIV infected and that he could infect others. He feared disclosure of his HIV status and elected not to change his lifestyle. Tony was connected with medical care. However, he reported coping with his illness by using condoms only occasionally and denying that anything in his life was wrong. The DIS linked Tony with prevention case management services to assist him in maintaining behaviors that would lower the risk of infecting others with HIV.

Charlotte's medical evaluation revealed that she had been infected for several years. Charlotte and her fiancé were married. She continues to utilize HIV-related community resources and is tolerating HIV medical therapy.

### **PS Initiated With Jerome**

Jerome, a bisexual male, was 52 years old when diagnosed with HIV infection after having tested negative ten months previously. Jerome was contacted and interviewed by a DIS and subsequently named five sexual partners. Case follow-up of the partners resulted in three persons testing negative, one person was not found due to lack of information, and one person, "Albert", testing positive.

Albert reported regular alcohol use and heavier use on the weekends. He met most of his sexual partners in gay bars and used condoms inconsistently. Albert reported that several of his past steady partners informed him about their HIV-positive status prior to their relationship with him. Albert denied having been tested previously for HIV. He provided demographic and locating information on as many persons as he reported remembering. Case follow-up was done on all named partners. His present steady partner tested negative for HIV.

During the PS session, Albert came to the conclusion that he needed assistance in establishing and maintaining risk reduction behavior. The DIS referred Albert to a prevention case management program at a local AIDS service organization. Because he lacked medical insurance and a regular medical care provider, he was also referred to a case management agency and linked to the county health department's HIV/AIDS clinic.

In addition, Albert was referred to a substance abuse treatment facility to address his alcohol abuse.

One of Jerome's partners, "Eunice", was located, counseled and consented to HIV testing. When the DIS conducted a risk assessment, Eunice acknowledged that she was unaware of any behaviors that would have put her at risk for HIV infection. The DIS discussed how HIV is and is not transmitted. Eunice admitted that she rarely used condoms with her partners and did not know if they had been tested for HIV. The DIS and Eunice came up with an individualized risk reduction plan that included consistent condom usage and how to negotiate condom usage with partners. The DIS and Eunice practiced role-plays that included various situations in which Eunice might find herself having to negotiate condom usage with her partners. The DIS also demonstrated how to put a condom on and let Eunice practice this skill. Eunice tested negative, and was scheduled to retest three months later.

## **Discussion**

The DIS in the cases discussed above faced several opportunities to increase awareness, provide education, and create an environment encouraging PS activities.

In the first case study, the DIS provided supportive education and information helpful for a young woman who was newly diagnosed with HIV infection and reported low risk behaviors. Further, PS activities identified a partner of the woman who was previously diagnosed with HIV. This resulted in re-initiation of PS and outreach to other clients who were uninformed of their risk.

In the second case study, a DIS assisted a client, newly diagnosed with HIV infection, with needed services. PS activities resulted in the confidential notification of a partner with high-risk behaviors who became aware of his HIV-positive status for the first time. The newly diagnosed partner was referred to several different programs that assisted the client in managing high-risk behaviors. A second partner, who tested negative, received important information on HIV that she previously was not aware of and was able to develop her own risk reduction plan. As a result, she was empowered, leading to a sense of better control over her life.

In both cases, the critically important HIV prevention services of education, counseling, testing, referral and linkage reached beyond the client who was first diagnosed and contacted by the DIS. The DIS and the client worked together to identify newly diagnosed individuals, previously diagnosed individuals who needed more assistance, and non-infected individuals that exhibited behaviors that increased their risk of acquiring HIV infection. These efforts create an opportunity for providing HIV prevention services that may work.



# **MODULE II**

## ***HIV/AIDS 501***

### ***Section C***

#### ***Quality Assurance/Quality Improvement***



## QUALITY ASSURANCE/QUALITY IMPROVEMENT OVERVIEW

Quality can be defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current knowledge. (Source: Institute of Medicine, Washington, D.C. 1990).

**Quality Assurance** is a systematic approach to ensuring a specific standard or level of care is met. Traditionally, this focuses on a few individuals detecting and solving special problems often identified through chart audits and other activities. Emphasis is placed on inspections, performance of individuals, human errors, and correction of failures.

**Quality Improvement** is a systematic, organization-wide approach to improving the overall quality of care through employee participation and team building. Emphasis is placed on customers. The processes (not individuals) are examined. Decisions are data driven.

The HIV/AIDS Section has adopted the CDC protocols for HIV prevention counseling. HIV prevention counseling, as currently described by the CDC, seeks to improve the ability of providers in a variety of settings to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV.

In order to ensure quality in a counseling, testing, and linkage (CTL) program one needs to make certain that services and materials are sensitive to the cultural, gender, age, linguistic, and reading comprehension levels of the population being served. The agency should provide brochures, posters, and videos in the languages spoken in their community. There should also be staff that is fluent in the languages of the local population.

### Documentation

Proper documentation provides evidence that services were offered and/or provided and that the site is in compliance with Department of Health policies. Appropriate documentation can also minimize the risk of future legal action.

Services should be documented in the client records and on the HIV counseling and testing forms, as specified in the HIV Counseling/Testing Forms Instruction Guide  
[http://www.doh.state.fl.us/disease\\_ctrl/aids/prevention/Counseling\\_Testing\\_Team.html](http://www.doh.state.fl.us/disease_ctrl/aids/prevention/Counseling_Testing_Team.html).

## Quality Improvement Reviews

The HIV/AIDS CTL Team and area Early Intervention Consultants (EICs) conduct quality improvement site visits to HIV test sites to assess the following:

- ☐ Accessibility of services, including hours of operation, location, etc.;
- ☐ Availability of supplies and materials such as brochures, posters, forms, condoms, etc.;
- ☐ Cleanliness of the facility;
- ☐ Pleasantness of front desk and other staff;
- ☐ Compliance with written policies, procedures, protocols, guidelines, rules, regulations, and laws;
- ☐ Cultural, linguistic, gender, and age appropriateness of services and materials;
- ☐ Monitoring of counseling sessions to evaluate counselor competence and provision of immediate feedback to counselor;
- ☐ Completion of 500/501 training and annual updates for HIV counselors;
- ☐ Supervision of HIV counselors and their competence, skills, training, etc.;
- ☐ Appropriateness of services to client needs;
- ☐ Documentation in client records and on counseling, testing, and linkage forms;
- ☐ Record keeping procedures, including confidentiality and security;
- ☐ Community resources (availability and collaborative arrangements); and
- ☐ County data review that includes testing trends and comparison of testing population to target population and/or populations with high positivity rates.

## Internal Quality Improvement Measures

Test sites should develop their own written quality assurance protocols, and should make them available to all staff providing CTL services. The quality assurance protocol should include all of the elements of the Department of Health review, including monitoring counseling sessions. **It is important to note that client permission should always be granted prior to a reviewer monitoring a counseling session.** Counselors should be given constructive feedback, emphasizing areas where he/she excels and areas where improvements can be made. This should never take place in front of clients or co-workers. Test sites can develop quality assurance teams to perform CTL program reviews on a semiannual or annual basis. Local EICs may assist with these reviews whenever possible. See the section entitled “QI Tools” for HIV counseling session and CTL program monitoring tools.

HIV counselors should conduct peer reviews to monitor each other’s counseling sessions (with client permission, of course) and to provide immediate constructive feedback. They should also have staff meetings or retreats with peers and supervisors to discuss difficult clients and/or situations that they have encountered and to hear how others have handled

similar situations. Local EICs can facilitate some of these meetings or retreats whenever possible.

### **Client Satisfaction Evaluation**

Evaluation of client satisfaction can ensure that services meet the client's needs. These evaluations can also provide important feedback to counselors who otherwise may not see the benefits of what they do. Client satisfaction should be assessed at least annually. The information obtained should be used for program enhancement. Your EIC may assist you in developing a client satisfaction survey.

# ***CHAPTER 1***

## ***HIV Counselor Competency***

## **HIV COUNSELOR COMPETENCY**

To ensure that clients accessing services at a publicly funded HIV test site receive the highest quality HIV prevention counseling, testing, and linkage (CTL) services, HIV counselors must be highly skilled in the provision of HIV prevention counseling. Training and updates are essential to developing and enhancing good HIV prevention counseling skills. HIV prevention counseling, when done correctly, has been proven to be very effective in helping clients reduce high-risk behavior. For this reason, it is vital that any person providing CTL services at a publicly funded HIV test site meets the requirements of IOP 360-07-17: Minimum Standards for HIV Counselors, Trainers, and Early Intervention Consultants. (See Section E: Resources).

It is not enough to just complete this course. Prior to going solo in an HIV counseling session, counselors must observe good HIV prevention counseling sessions and be observed providing HIV prevention counseling by an expert in HIV prevention counseling. It is also crucial that counselors attend annual 501 updates to enhance their HIV prevention counseling skills, to increase their knowledge of HIV prevention services, and to be informed of other issues impacting CTL services.

The following consists of the prerequisites, requisites, and post-requisites for HIV/AIDS counselors at publicly funded HIV test sites, including Department of Health employees, contract/memorandum of agreement (MOA) providers, and volunteers who provide CTL services:

### **Pre-Requisites to HIV/AIDS 501 Training**

1. The participant must have had the HIV/AIDS 500 pre-requisite course, no longer than six months prior to registration for the HIV/AIDS 501 course.
2. The participant must successfully complete the prerequisite module prior to participation in the HIV/AIDS 501 course.
3. The participant must complete the registration package, including the disclaimer form, and return to the trainer prior to the class.

### **Requisite Course Activities – HIV Counselors**

1. The participant must attend the entire training. In the event of an emergency, the instructor may make other course completion arrangements at his/her discretion.
2. The participant must demonstrate skills learned through required course exercises.
3. The participant's skills will be consistent with standards outlined in IOP 360-09-17: Provision of HIV Prevention Counseling, Testing and Linkage Services.

## **Post-Training Requisites – HIV Counselors**

1. All counselors will observe a **minimum** of one pre-test counseling session, one HIV-negative post-test counseling session and one HIV-positive post-test counseling session.
2. All counselors will perform a **minimum** of one pre-test counseling session, one HIV-negative post-test counseling session and one HIV-positive post-test counseling session under the supervision of an experienced counselor.

*\* Role plays are acceptable on a case-by-case basis for the HIV-positive post-test counseling sessions.*

**As an HIV counselor, you must make a commitment to quality in the provision of CTL services; otherwise, you are doing a disservice to clients and possibly jeopardizing their ability to make good informed choices in reducing their risk. The level of sensitivity used when interacting with and/or eliciting information from clients can also make a difference in whether or not they return for results and/or reduce their risk.**

## HIV/AIDS Counselor/Trainee Evaluation Checklist

<b>Print Name of Trainee</b>	<b>Print Name of HIV/AIDS 501 Trainer</b>
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**Instructions:** Staff who performs HIV counseling and testing activities within county health departments and contracted providers will be held to the minimum standards outlined in Technical Assistance: TAG 345-17-12. This form is to be completed by the AIDS 501 Trainer and the Supervisor of the HIV Counselor/Trainee. *Please sign and date in all of the appropriate boxes.*

### ***Pre-Requisites to HIV/AIDS 501 Training***

Completed HIV/AIDS 500	No	Yes	<b>Date</b>	<b>Trainer (Print &amp; Sign)</b>	<b>Comments</b>
Successfully completed the HIV/AIDS 501 Pre-Test	No	Yes	<b>Date</b>	<b>Trainer (Print &amp; Sign)</b>	<b>Comments</b>

### ***Requisite Course Activity***

Attended HIV/AIDS 501 course	No	Yes	<b>Date</b>	<b>Trainer (Print &amp; Sign)</b>	<b>Comments</b>
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### ***Trainer's Evaluation of Trainee Counselor:***

<b>Participation</b>
<b>Grasp of Concepts/Topics</b>
<b>Strengths</b>
<b>Weaknesses</b>
<b>Other</b>

## HIV/AIDS Counselor/Trainee Evaluation Checklist

### **Post-Training Requisites**

*All post-training requirements need to be **completed within 60 days** of HIV/AIDS 501 Training. Opportunities for observation and performance of post-test positive counseling may be limited in smaller counties. When there is no other option, a role-play may be done. The 60 day requirement may be extended, as needed.*

*All new counselors/trainees will observe a minimum of one pre-test counseling session, one HIV-negative post-test counseling session and one HIV-positive post-test counseling session of an experienced counselor. The experienced counselor should sign below after being observed by the trainee.*

<b>Pre-test</b>	<b>Date</b>	<b>Experienced Counselor</b>	<b>Comments</b>
<b>Post-test negative</b>	<b>Date</b>	<b>Experienced Counselor</b>	<b>Comments</b>
<b>Post-test positive</b>	<b>Date</b>	<b>Experienced Counselor</b>	<b>Comments</b>

*All counselors/trainees will perform a minimum of one pre-test counseling session and one HIV-negative post-test counseling session under the supervision of an experienced counselor. The new HIV counselor/trainee must demonstrate skills learned through the required course exercises. The experienced counselor should sign below after observing the trainee.*

<b>Pre-Test/Informed Consent</b>	<b>Date</b>			<b>Experienced Counselor</b>
<b>During the session, the counselor/trainee:</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comments</b>
1. Introduced self				
2. Established a rapport with the client				
3. Defined the purpose of the session				
4. Assessed client need for service				
5. Informed client of their right to withdraw at anytime				
6. Explained confidentiality				

## HIV/AIDS Counselor/Trainee Evaluation Checklist

During the session, the counselor/trainee:	Yes	No	NA	Comments
7. Explained the difference between anonymous and confidential testing				
8. Explained HIV infection reporting				
9. Assessed client risk(s) for HIV				
10. Provided accurate and factual information				
11. Described testing purpose				
12. Described testing procedures				
13. Explained the meaning and limitations of the test result				
14. Assessed safer sex practices and demonstrated condom use, if appropriate.				
15. Discussed needle sharing partners				
16. Advised against donating blood and blood products, sperm or eggs, and any human tissue, organ or fluid during the two-week waiting period for results				
17. Discussed personal risk reduction measures				
18. Answered client questions effectively				
19. Reinforced risk reduction message				

## HIV/AIDS Counselor/Trainee Evaluation Checklist

During the session, the counselor/trainee:	Yes	No	NA	Comments
20. Set follow-up appointment for client to return, if necessary, and gave it in writing				
21. Used effective verbal and non-verbal communication				
22. Referred/linked to other services, including primary care, family planning, STD, prenatal/OB, community resources, support groups, TB screening, alcohol, drug abuse and mental health services, etc.				
23. Accurately documented the contact in the medical record/client file and on lab slip				

Post-Test Negative	Date			Experienced Counselor
During the session, the counselor/trainee:	Yes	No	NA	Comments
1. Introduced self and explained purpose of session				
2. Confirmed identity				
3. Reminded client of confidentiality				
4. Provided result clearly and simply				
5. Assessed client's understanding of test result, including the window period and need to retest				

## HIV/AIDS Counselor/Trainee Evaluation Checklist

During the session, the counselor/trainee:	Yes	No	NA	Comments
6. Reviewed client's risk reduction plan and revised, as necessary (safer sex practices, needle-sharing, condoms, etc.)				
7. Answered client questions effectively				
8. Used effective verbal and non-verbal communication (e.g., open-ended questions)				
9. Advised against donating blood and blood products, sperm or eggs, and any human tissue, organ or fluid if client is still at risk for HIV infection				
10. Recommended appropriate referrals/made appropriate linkages (Such as to other services, including primary care, family planning, STD, prenatal/OB, community resources, support groups, TB screening, alcohol, drug abuse and mental health services, etc.)				
11. Provided accurate and factual information				
12. Accurately documented the contact in the medical record/client file and on lab slip				

*Observation of a post-test positive session is not required to meet HIV/AIDS 501 post-requisites; however, it is strongly encouraged.*

Post-Test Positive	Date			Experienced Counselor
During the session, the counselor/trainee:	Yes	No	NA	Comments
1. Introduced self and explained purpose of session				

2. Confirmed identity				
3. Reminded client of confidentiality				
4. Provided result clearly and simply, allowed client to process result				
5. Assessed client's understanding of test result and how they are coping				
6. Recommended appropriate referrals/made appropriate linkages <i>(Such as to other services, including medical care, case management, PS, family planning, STD, community resources, support groups, TB screening, alcohol, drug abuse and mental health services, etc.)</i>				
7. Linked pregnant female to local programs, including TOPWA, Healthy Start, and prenatal care				
8. Advised against donating blood and blood products, sperm or eggs, and any human tissue, organ or fluid during the two-week waiting period for results				
9. Advised against donating blood and blood products, sperm or eggs, and any human tissue, organ or fluid				
10. Answered client questions effectively				
11. Used effective verbal and non-verbal communication (e.g., open-ended questions)				
12. Provided accurate and factual information				
13. Accurately documented the contact in the medical record/client file and on lab slip				

## HIV/AIDS Counselor/Trainee Evaluation Checklist

Additional Comments

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My signature below verifies that \_\_\_\_\_ has successfully  
(Name of Counselor/Trainee)

completed the pre-requisite, requisite, and post-requisite "HIV/AIDS 501 Counselor" training requirements.

_____ <b>Supervisor</b>	_____ <b>Date</b>	_____ <b>Experienced Counselor</b>	_____ <b>Date</b>
_____ <b>Trainer</b>	_____ <b>Date</b>		

Certificate of Attendance sent: \_\_\_\_\_

Certificate of Completion sent: \_\_\_\_\_

# ***CHAPTER 2***

## ***QI Tools***

## HIV EARLY INTERVENTION MEDICAL RECORDS REVIEW

Date:		Reviewed by:						Site Number(s):		
#	DH 1628 and/or CHART							DH 1818	DH 1628c and/or Chart	
	A) Scan #	B) Demographics	C) Test History	D) Risk Assessment	E) Rapid Test	F) Post-Test Counseling	G) Linkages and Referrals	H) Informed Consent	I) No shows documented	J)
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
<b>TOTALS:</b>										

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## HIV EARLY INTERVENTION MEDICAL RECORDS REVIEW

**DIRECTIONS - Document actual information requested or "Y" for Yes and "N" for No as stated below, in boxes provided.**

- A. **Scan #** - Document scan number from the DH 1628.
- B. **Demographics** – DH 1628 contains demographic and contact information (Yes or No)?
- C. **Test History** – DH 1628 contains HIV test history and the previous positive section is completed, if applicable (Yes or No)?
- D. **Risk Assessment** – Client was risk assessed as indicated on the DH 1628 and/or DH 1628c (Yes or No)?
- E. **Rapid Test** – DH 1628 contains completed, accurate “RAPID TEST USE ONLY” information, if applicable (Yes or No)?
- F. **Post-Test Counseling** – The DH 1628c was completed, the client was post-test counseled and the form sent to Tallahassee. Write N/A if client has not returned for test results. Check for reporting to STD, if positive.
- G. **Linkages and Referrals** – The medical record reflect referrals and linkages to PS, medical care and treatment, needed prevention or other services.  
Linkages made and followed up on to ensure completion (Yes or No)?
- H. **Informed Consent** – Please put a “Y” if **ALL** of the factors below have been met, and an “N” if they have not been met on the DH 1818.
1. The DH 1818 is **signed** by the client (confidential test)  
**OR**  
The scan number is written in place of the signature, or the scan number label is affixed (anonymous test)
  2. The counselor witnessed the consent form
  3. The consent form is dated
  4. The appropriate boxes are initialed or checked.
- I. **Other/Comments** – Document any pertinent general comments regarding all/most of the records or specific comments about a particular record identified by the number on the far left.

**Note: All instructions above are applicable to sites using the state lab and Department testing forms. If you are reviewing records of a testing site that is *not* using the state lab, you will need to consult with appropriate staff of that facility to find informed consent or other related documents. Some sections of the record review form will not apply if the state lab is not used.**



# HIV EARLY INTERVENTION QUALITY IMPROVEMENT/TECHNICAL ASSISTANCE CHECKLIST

Person  
Interviewed:  
Interviewed by:  
Date:

I. Services Review Interview	
AREA	ISSUES/FINDINGS
A. Is a current certificate of registration displayed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. What days and times are services available?	
C. How much is charged for an HIV test? Anonymous \$ _____ Confidential \$ _____ Conventional \$ _____ Rapid \$ _____	1. Is sliding scale available? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Is fee waiver available? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. How is the sliding scale or waiver discussed with the client?
D. Has everyone who provides HIV counseling (and is required to) successfully completed the HIV/AIDS 500/501 course, including the requirements of TAG: 345-17-12 ?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "No" please explain:
E. Has everyone who provides HIV testing completed the HIV/AIDS 501 annual update?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "No" please explain:
F. Assess the clinic flow for clients (e.g. how do clients move through the testing process?).	
G. What are some of the barriers to clients accessing counseling and testing services (e.g., clinic hours, location, language, confidentiality concerns, transportation, etc.)?	1. Barriers:  2. What has been done to eliminate these barriers?

## HIV EARLY INTERVENTION

### QUALITY IMPROVEMENT/TECHNICAL ASSISTANCE CHECKLIST

Person

Interviewed:

Interviewed by:

Date:

<p><b>H. How do clients know when to return for results? (e.g., are they given an appointment, return appointment card from DH 1628, and/or another appointment card?)</b></p>	
<p><b>I. What is done to encourage clients to return for post-test counseling?</b></p>	
<p><b>J. According to staff, why do clients not return for results?</b></p>	
<p><b>K. What happens when HIV-positive clients do not return for results?</b></p>	<p><b>Is client and positive test information reported to STD within one (1) working day of missed appointments?</b></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>If “No”, please explain when client and missed appointment information are relayed to STD?</b></p>
<p><b>L. How is partner services (PS) being offered?</b></p> <p><b>What are some barriers in offering/providing PS?</b></p>	
<p><b>M. How does HIV infection reporting occur?</b></p> <p><b>1. Who does the reporting?</b></p> <p><b>2. How soon are cases reported?</b></p>	

## HIV EARLY INTERVENTION

## QUALITY IMPROVEMENT/TECHNICAL ASSISTANCE CHECKLIST

**Interviewed:**

Date:

N W

- N. What is the process for linking clients to medical and referring to non-medical services?**
- 1. Who makes the referral/linkages?**
- 2. How soon are clients given an appointment and seen?**
- 3. What happens if clients do not keep appointments?**
- 4. What type of relationship has been established with provider(s)(e.g. good, bad, other; MOA, Business Associate Agreement)?**

O. What are some barriers to clients accessing medical and non-medical services (e.g., clinic hours, location, confidentiality concerns, transportation, language, etc.)?	<p><b>1. Barriers:</b></p>  <p><b>What has been done to eliminate these barriers?</b></p>
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<p><b>P. What additional literature, information, or training would be beneficial for staff?</b></p>	
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<b>Additional Comments:</b>	
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## II. Security of Medical/Confidential Information

AREA	ISSUES/FINDINGS
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## HIV EARLY INTERVENTION

### QUALITY IMPROVEMENT/TECHNICAL ASSISTANCE CHECKLIST

Person

Interviewed:

Interviewed by:

Date:

<b>A. Is there an authorized access list for the records room/files?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	If “No” please explain:
<b>B. Is there a sign-in log for others to access records room/files?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	If “No” please explain:
<b>C. Where are records kept?</b>	<b>Are positive records isolated from other records?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  If “Yes” please explain:
<b>D. Are records secured?</b> 1. Double locks used? 2. Stationary file cabinets? 3. Stationary ceiling in room? 4. Windowless room or secured windows (security barriers/alarm)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>E. Were any records left unsecured outside of the records area?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	If “Yes” please explain:  Was an incident report completed for this? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>F. Were there audible security/confidentiality breaches?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	If “Yes” please explain:
<b>G. Were computer monitors placed out of the view of clients, visitors, and/or unauthorized personnel?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	If “No” please explain:
<b>H. Were clients, visitors, and/or unauthorized personnel observed alone in secured areas</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	If “Yes” please explain:

# HIV EARLY INTERVENTION QUALITY IMPROVEMENT/TECHNICAL ASSISTANCE CHECKLIST

Person  
Interviewed:  
Interviewed by:  
Date:

<b>I. How is security addressed and confidentiality protected when information is taken out to the field and/or transported?</b>	
<b>J. Who provides janitorial maintenance of the records room and/or secured areas?</b>	<b>Clinic Staff</b> <input type="checkbox"/> <b>Private Company</b> <input type="checkbox"/> <b>If private company, when are these services provided, and how are they supervised?</b>
<b>K. Were there any other security-related concerns?</b>  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	<b>If “Yes” please explain:</b>

**Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# HIV EARLY INTERVENTION

## QUALITY IMPROVEMENT/TECHNICAL ASSISTANCE CHECKLIST

Person  
Interviewed:  
Interviewed by:  
Date:

Rapid Test Sites			
ISSUES/FINDINGS			
Temp logs completed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Test result logs completed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Control logs completed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Copy of reactive result log on file?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Corrective action log completed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Does the agency have a QA Manual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
What system is in place to ensure all 1628s are sent to Tallahassee by the deadline?			
Are rapid test supplies properly stored?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Current Biohazardous Waste Permit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Current CLIA Waiver displayed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Has everyone who conducts rapid testing completed Department approved rapid test training?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# **MODULE II**

## ***HIV/AIDS 501***

### ***Section D***

### ***Wrap Up***



# ***CHAPTER 1***

## ***Taking Care of Self***

## TAKING CARE OF SELF

Counselors providing HIV counseling and testing services encounter extremely difficult and stressful situations in their day-to-day work, especially when giving positive test results. Counselors may also work with the families and loved ones of HIV-positive individuals, adding to the emotional challenge. Many times in the process of taking care of others we forget to take care of ourselves. Often the signs and symptoms of the emotional strain or "burnout" sneak up on us. It is important to recognize these signs and symptoms for yourself as well as others working in the field. The following is a list of some common possible symptoms of burnout:

Blaming	Impatience	Chronic Fatigue
Exhaustion	Detachment	Denial of Feelings
Boredom	Defensiveness	Psychosomatic complaints
Cynicism	Depression	Inability to let go

While the presence of these symptoms may indicate the beginnings of burnout, there may be other causal factors involved.

## Self-Assessment for Counselors

Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Site #: \_\_\_\_\_

Counselor Name/#: \_\_\_\_\_ (optional)

How long have you been doing HIV counseling? \_\_\_\_\_

Please be as specific as possible and  
use the back for additional space

Counselor Assessment	Minimal	Moderate	High	Comments
What has been the impact of your counseling on clients?	1	2	3	
How well do you feel that you elicit information from your clients during risk assessment and counseling sessions?	1	2	3	
How well do you feel that you personalize each client's risk reduction plan?	1	2	3	
How beneficial are the trainings and updates at meeting your needs?	1	2	3	
How much support do you feel that you get from your supervisor?	1	2	3	
How much support do you feel that you get from your peers?	1	2	3	

1. What skills do you feel you are lacking or need improvement? \_\_\_\_\_

2. What kinds of work overload, stress, and/or burnout, are you experiencing; how are you managing it?

3. What resources do you have access to for stress management? \_\_\_\_\_

4. What suggestions do you have for burnout prevention and/or stress management? \_\_\_\_\_

5. What major unmet needs do you have now or foresee in the future? \_\_\_\_\_

6. On a scale from 1-10 (with 10 being the highest) how do you rank your performance as a counselor and why?

Additional Comments: \_\_\_\_\_



# ***CHAPTER 2***

## ***Putting It All Together***

## PUTTING IT ALL TOGETHER

**Congratulations, you have made it through the academic portion of the HIV/AIDS 501 course!** Now, you must finish the practicum portion of the course in order to complete your training as an HIV counselor.

You received a great deal of information in a short period of time and it may feel overwhelming. All of the information provided throughout the HIV/AIDS 500 and 501 courses are vital to the provision of good quality HIV prevention counseling, testing, and linkage services. Here is a brief summary of the modules:

### HIV/AIDS 500 Module

- ❑ **The Basics of HIV/AIDS** – This chapter included information on the history of HIV/AIDS, the origin of the virus, immunology, virology, opportunistic infections and conditions, the disease spectrum and treatment, epidemiology, and a discussion of legal and ethical issues.
- ❑ **Transmission and Prevention** – This chapter provided information on how HIV is transmitted and how it is prevented. Abstinence, mutual monogamy, cleaning/not sharing needles, and condom use were also included in this chapter.
- ❑ **HIV Counseling, Testing, and Linkage** – The HIV CTL chapter presented an overview of HIV prevention counseling and information on the types and methods of available testing (antibody vs. antigen and anonymous vs. confidential), alternative testing technologies (oral, blood, rapid, etc.), the meaning of test results, partner services (PS) for clients testing HIV positive and reactive, and an overview of types of linkages and referrals that clients may need.
- ❑ **Infectious Diseases** – The chapter on infectious disease included information on sexually transmitted diseases (STD), tuberculosis (TB), and hepatitis including signs and symptoms, treatment, complications, co-infection and co-morbidity, partner notification/contact investigation, and available clinical services.
- ❑ **Participant Self Assessment** – This tool allowed potential counselors to assess their thoughts, feelings, and comfort level in dealing with certain circumstances and populations.

### HIV/AIDS 501 Module

#### Section A: HIV Prevention Counseling

- ❑ **Communication and Counseling Skills** - This chapter addressed verbal and nonverbal communication as well as basic counseling skills.

- **Fundamentals of HIV Prevention Counseling** – This chapter provided more in-depth information on HIV prevention counseling, including its goal, basic counseling skills and concepts, and the CDC's six steps.
- **Cultural Competency** – The cultural competency chapter provided explanations of the various aspects of culture, information on how counselors can become more culturally competent, essential knowledge, skills, and abilities of cultural competency, cultural terminology, and the cultural continuum.
- **Special Populations/Situations** – This chapter addressed the unique challenges of providing HIV prevention CTL services to special populations including pregnant women, persons in violent relationships, persons with impaired judgment due to substance use and abuse, men who have sex with men (MSM), youth, persons over age thirty, incarcerated populations, persons who test frequently and continue to place themselves at risk, homeless populations, vaccine trial participants, and persons with a possible exposure (occupational or non-occupational). Provision of services in nontraditional (outreach) settings was also explored in this chapter, including privacy and confidentiality, informed consent, counseling, testing, and linkage, record keeping, and safety.
- **HIV Risk Assessment** – In this chapter, the protocol for conducting a client-centered risk assessment was presented, along with a summary sheet on eliciting information in an open-ended manner.
- **HIV Pre-Test Counseling, Informed Consent and Post-Test Counseling** – This chapter presented important skills for counselors to remember when conducting pre- and post-test counseling sessions, including appropriate protocols. In addition to this information, various “cheat sheets” were provided for pre-test, negative/indeterminate post-test, and positive post-test counseling.

## **HIV/AIDS 501 Module**

### **Section B: Referrals and Linkages**

- **HIV/AIDS Patient Care Programs** - In this chapter, an overview of Ryan White Title II, AICP, ADAP, CHD Patient Care Network, and housing were presented.
- **Partner Services (PS)** – In the PS chapter, the history, benefits, essential concepts, referral processes, interview period, and counselor role in PS were explored.

## **HIV/AIDS 501 Module**

### **Section C: Quality Assurance/Quality Improvement**

- **Quality Assurance/Quality Improvement (QA/QI)** – An overview of (QA/QI) was presented including the importance of documentation, QI reviews, internal QI

measures that counselors and programs can implement, and client satisfaction evaluations.

- **HIV Counselor Competency** – This chapter covered the importance of completing the requirements of TAG 345-17-12: Minimum Standards for HIV Counselors, Trainers, and Early Intervention Consultants and attending annual HIV/AIDS 501 updates.
- **QI Tools** – In this chapter, tools used by the Department of Health were presented.

## **HIV/AIDS 501 Module**

### **Section D: Wrap Up**

- **Putting It All Together** – This chapter summarizes the 500 and 501 courses.
- **Taking Care of Self** – An assessment and information on preventing counselor stress and “burnout” is presented.

**Counselor Self-Assessment** – A tool is provided to assist counselors in assessing their skill level, training needs, and support systems.